

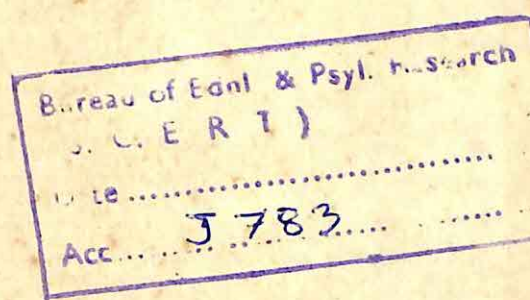
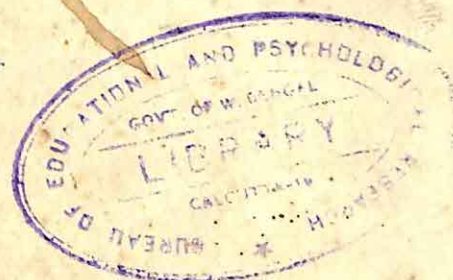
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Cigarette smoking: natural history of a dependence disorder

BY M. A. HAMILTON RUSSELL*

In 1604 King James I, in his celebrated counterblast to tobacco, referred to smoking as 'a branch of the sin of drunkenness, which is the root of all sins'. We no longer regard alcoholism in moral terms but recognize it as a complex psychological illness. How right King James was, almost 400 years ago, to point out what many fail to see today, i.e. to ally smoking and alcoholism; for that is where it belongs, together with dependence on heroin, barbiturates, amphetamines and other dependence-producing drugs.

Not only is smoking associated with normal drinking (McKinnell & Thomas, 1967), but it is also statistically linked with alcoholism. A study of psychiatric out-patients showed that 92 per cent of alcoholics were smokers compared with 50 per cent of 'neurotics' attending the same hospital. Furthermore, the alcoholics also tended to smoke more heavily (Dreher & Fraser, 1968). Other studies have shown that smoking is associated with other drug use as well as with drinking. In a sample of delinquent boys 19 per cent of the non-smokers were regular drinkers and only 6 per cent had used drugs, compared with 40 and 21 per cent respectively of the heavy smokers (Backhouse & James, 1970). In a sample of registered heroin addicts attending clinics in London 99 per cent were smokers (Stimson & Ogborne, 1970, personal communication), whereas 58 per cent of the general population smoke (Todd, 1969). Moreover, heroin addicts and other drug users tend to smoke more heavily and to have started at an earlier age than the general population. The association of smoking with alcoholism and other drug

use, together with recent findings of the high rate (95 per cent) of barbiturate and other sedative use among heroin addicts (Stimson & Ogborne, 1970, personal communication; Mitcheson *et al.*, 1967), indicates that we are in an era of polydrug use, and where these drugs, which include nicotine, are used, there is a danger of dependence.

We can no longer afford to regard cigarette smoking as a 'minor vice'. It is neither minor, nor a vice, but a psychological disorder of a particularly refractory nature and all the evidence places it fair and square in the category of the dependence disorders. Its management and control is no less pressing than that of other dependence-producing substances. Indeed, the effective control of cigarette smoking is potentially the most important health measure that is likely to be open to us for the rest of this century. It is the belief that all dependence disorders may be in some way related, and that cigarette dependence is an important member of this group, that has prompted the Addiction Research Unit of the Institute of Psychiatry, London, to add cigarette smoking to its field of study.

THE MEANING OF DRUG DEPENDENCE

The separation of drug abuse into the two categories 'habituation' and 'addiction' was never satisfactory. In 1964 the World Health Organization proposed use of the single term 'dependence' and suggested that each drug produced its own type of dependence which could be predominantly either 'physical' or 'psychological'. Physical dependence is generally held to involve the presence of physiological adaptive changes (Paton, 1969*b*; Collier, 1969). These include: (i) tolerance of the effects of the drug due primarily to

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changes at synapses, but also, in some cases, to increased capacity to metabolize and excrete the drug as a result of enzyme induction, mainly in the liver; (ii) withdrawal symptoms resulting from rebound overactivity at synapses, when intake of the drug is reduced or discontinued. On the other hand, psychological dependence is believed to have no such underlying physiological mechanisms.

It is becoming appreciated that this customary distinction between physical and psychological dependence is a fine one. Strong dependence may occur in the absence of a classical withdrawal syndrome. Psychological processes are mediated by physiological events. Intense subjective craving, so long regarded by the unsympathetic as 'merely psychological', may well be governed by physiological adaptive mechanisms in the hypothalamic reward system which are no less 'physical' than the similar mechanisms, involving the peripheral autonomic nervous system, responsible for many of the classical phenomena of opiate withdrawal. Refined techniques are revealing physical effects of withdrawal of drugs such as amphetamines, hitherto regarded as capable of inducing psychological dependence only (Oswald & Thacore, 1963; Oswald *et al.*, 1969). On the other hand, the opiate withdrawal syndrome, so long regarded as pathognomonic of the physically dependent state, may occur as a classically conditioned response (Vaillant, 1969) and can also be induced by hypnosis (Ludwig & Lyle, 1964). The importance of psychological dependence has tended to be underrated, yet it may pose just as great a treatment problem as physical dependence. It would therefore seem more meaningful (especially when confronted with the individual case) to emphasize the degree of dependence rather than the type of dependence along physical and psychological dimensions.

A definition of dependence was provided by Professor W. D. M. Paton at the opening of a Symposium on Drug Dependence in April 1968 (Paton, 1969*a*) when he suggested

that 'drug dependence arises when as a result of giving a drug, forces—physiological, biochemical, social or environmental—are set up which predispose to continued drug use'. This definition seems too broad and also misses the essential point—it is not frequent or continued use so much as difficulty in refraining from use that denotes dependence. One may drink orange juice, neat or with water, several times a day and not be dependent on it in the drug sense, provided it can be discontinued without discomfort or difficulty; yet a few drinks of alcohol on occasional evenings if they were not easy to forgo would represent a degree of dependence. A person would not be dependent on ascorbic acid *because* he ate several oranges a day; but we are dependent on ascorbic acid *because* we would die without it. This is not, however, the sort of dependence we imply when we speak of drug dependence or indeed of any form of psychological dependence. For our purpose the notion of dependence on a drug, object or activity requires the crucial feature of negative affect experienced in the absence of that drug, object or activity. The degree of dependence can be equated with the amount of this negative affect, which may range from mild discomfort to extreme distress, or it may be equated with the amount of difficulty or effort required to do without the drug, object or activity. How high a degree of dependence is required before a dependence disorder is termed an addiction is somewhat arbitrary.

THE NATURE OF CIGARETTE DEPENDENCE

Since its introduction to Europe in the 16th century, the use of tobacco has not only become widespread but has survived considerable official disfavour. It has in the past been cause for excommunication, death, public whipping and cutting off the nose. These penalties had as little effect on its popularity then as do threats of lung cancer and exorbitant taxation today. Tobacco taking has fluctuated between chewing, snuffing and smoking, but since its inception no population

has dispensed with one form of tobacco use without replacing it by another. The only time the British population has given up smoking was in the 18th century, when it switched to snuffing for almost 100 years. Where tobacco is not used coca leaf or betel nut serve a similar purpose. Furthermore, betel nut contains arecoline, an analogue of nicotine. Thus some form of elaborate non-nutritive hand-mouth activity associated with the taking of a stimulating alkaloid has been part of the human behaviour repertoire for almost 500 years. Once experienced, nicotine use has continued in populations as it does in individuals.

As many as three out of four smokers wish to or have tried to stop their smoking, but less than one in four ever succeeds in becoming a permanent ex-smoker (see below). Thus most smokers only continue smoking because they cannot easily stop. This sad state is one of the features of a dependence disorder. Of those who profess to be happy about their smoking some are ignorant but the majority use face-saving psychological defence mechanisms such as 'rationalization' and 'denial' to avoid uncomfortable inconsistency between attitude and behaviour. By these devices they blind themselves to the health hazards, the financial expense and the control that their smoking has over them.

It is far easier to become dependent on cigarettes than on alcohol or barbiturates. Most users of alcohol or sleeping tablets are able to limit themselves to intermittent use and to tolerate periods free of the chemical effect. If dependence occurs it is usually in a setting of psychological or social difficulty. Not so with cigarettes; intermittent or occasional smoking is a rarity—about 2 per cent of smokers (McKennell & Thomas, 1967). If he smokes at all, the most stable well-adjusted person sooner or later becomes a regular dependent user (or misuser)—in other words, he is hooked. Furthermore, it requires no more than three or four casual cigarettes during adolescence virtually to ensure that a person will eventually become a regular

dependent smoker. Only about 15 per cent of those who have more than one cigarette avoid becoming regular smokers (McKennell & Thomas, 1967). In the prevailing social climate it is only intravenous drugs which have anything like the dependence-producing potential of cigarette smoking, and it may be no coincidence that the absorption of nicotine through the lungs during smoking is about as rapid and efficient as the junkie's 'fix'.

That withdrawal of cigarettes from heavy smokers may cause a subjectively distressed state is widely appreciated. Such symptoms as depression, anxiety, irritability, restlessness, intense craving and difficulty in concentration have frequently been described. Some of these withdrawal effects may even occur with 'blind' substitution of low-nicotine cigarettes (Finnegan *et al.*, 1945; Knapp *et al.*, 1963). A single study has shown that they can be allayed by injections of nicotine, which are pleasurable to smokers but not to non-smokers (Johnston, 1942). More recently, objective physical withdrawal effects have been clearly demonstrated and include sleep disturbance, sweating, gastrointestinal changes, drop in pulse rate and blood pressure, disturbed time-perception (Knapp *et al.*, 1963), impaired performance at simulated driving (Heimstra *et al.*, 1967) and EEG changes (Ulett & Itil, 1969).

Before he can enjoy inhaling deeply, the novice must acquire a degree of tolerance to the local irritation and autonomic side-effects of smoking. Some tolerance is quickly acquired but it usually takes 2 or 3 years before the smoking pattern is such as to enable a high nicotine intake. A different aspect of tolerance is revealed by studies of urinary nicotine excretion, which have shown that non-smokers excrete as unchanged nicotine a greater portion of a given dose than do smokers (Beckett & Triggs, 1967). This suggests that in smokers recurrent exposure to nicotine may induce enzyme changes that are responsible for the altered nicotine kinetics. Thus there is evidence that, in addition to

psychological dependence, most cigarette smokers fulfil the criteria for physiological dependence, namely tolerance and physical withdrawal effects.

The smoking of three cigarettes an hour enables the heavy smoker to maintain the 20 minute peak level of nicotine effect more or less continuously throughout his waking life. There is little doubt that withdrawal of this chronic nicotine intoxication causes a clear-cut withdrawal syndrome. This type of smoker will usually reach for a cigarette first thing on waking, will seldom go more than an hour without a cigarette and, should his supply run out, will go to great lengths to obtain more. Though most smokers do not suffer this extreme degree of dependence, they are still dependent. It is only the exceptional 2 per cent who smoke occasionally and intermittently who are truly non-dependent smokers.

CAUSES OF CIGARETTE SMOKING

Once we realize that we are dealing with a dependence disorder we must expect complexity. Smoking is no exception. There is no single cause except the obvious one, namely the existence of tobacco. If tobacco were to disappear cigarette dependence would vanish with it. This is of course not feasible. We are therefore forced to tackle the problem from the other end and attempt to disentangle the complicated interaction of many factors that determine why some people smoke while others do not. If we want to know why people smoke, why do we not just ask them? Most smokers are at a loss to provide a satisfactory answer. Two scientific approaches have in the main been used to investigate this question: (i) the study of differences between smokers, non-smokers and ex-smokers; (ii) neuropharmacological studies of nicotine. A number of determining factors have been identified which are conveniently dealt with under the following five headings: genetic, personality, social, sensorimotor and pharmacological factors. Separation of these factors is, however,

a little artificial as they are so interrelated; for example, one's personality is moulded by social influences, while at the same time determining to some extent which social environment one chooses to live in.

Genetic factors. There are powerful proponents (Berkson, 1963; Eysenck, 1965; Fisher, 1959; Seltzer, 1963, 1967) of the view that genetic factors are strong determinants of smoking behaviour. The suggestion is that cancer-proneness, extraversion, a pyknic build and a tendency to smoke are inherited together. The association with body build has since been shown to be due to sampling errors (Peters & Ferris, 1967). Twin studies, however, do provide some support for a contribution from genetic factors, in that identical twins, even if reared apart, are more concordant in their smoking habits than non-identical twins (Fisher, 1958; Todd & Mason, 1959; Friberg *et al.*, 1959; Raaschou-Nielsen, 1960). A positive association between smoking and the inherited ability to taste phenylthiourea (Thomas & Cohen, 1960) and a negative relation to blood group B are difficult to interpret (Cohen & Thomas, 1962). All in all, the role of genetic factors in determining smoking behaviour appears to be small compared with the influence of the environment.

Personality factors. Many workers have attempted to identify a 'smoking type'. Significant differences between smokers and non-smokers have been found but the distinctions are small and show considerable overlap. Smokers tend to be impulsive, arousal seeking, danger-loving risk-takers who are belligerent towards authority. They drink more tea, coffee, alcohol; are more prone to car accidents, divorce and job changing (Schubert, 1959; Straits & Sechrest, 1963; Heath, 1958; Lilienfeld, 1959; Jacobs *et al.*, 1966). Smokers also tend to be more sexy: not only do they start at an earlier age, but they indulge with greater frequency, variation and enjoyment (Schofield, 1965; Giese & Schmidt, 1968). All these characteristics cluster with a degree of extraversion. Several studies have shown that

smokers are more extraverted than non-smokers (Eysenck *et al.*, 1960; Eysenck, 1963, 1965; Smith, 1967). Although these results are highly significant statistically, the differences are so small as to be of little predictive value. Thus out of a possible Eysenck Personality Inventory Extraversion score ranging from 0 to 24, the mean of non-smokers and heavy smokers differs by less than 1 point and both lie between 6.9 and 7.9 (Eysenck, 1965).

Claims that smokers tend to be more tense, anxious, emotional and neurotic have not been generally substantiated (Eysenck, 1963; Smith, 1967), and such characteristics are as likely to be a consequence as a cause of smoking. The familiar figure of the heavy smoker as a tense, restless person who cannot sit still for long may well be suffering from the effects of chronic nicotine intoxication rather than the possessor of an anxious neurotic personality in need of constant tranquillization.

An oral basis to smoking has been suggested by psychoanalysts. Smoking is viewed as a gratification of unfulfilled oral needs stemming from frustrations in early infancy (Fenichel, 1945). This is supported by the relation of smoking (especially after withdrawal) to other oral activity such as nail-biting, gum chewing, sweet eating and general ingestion of food and drink. An association has been found between the ability to stop smoking and the age of weaning. Those who stopped easily were weaned at an average age of 8 months, whereas those unable to stop were weaned at an average of 4.7 months (McArthur, *et al.*, 1958). Monkeys are more readily induced to smoke if they have suffered parental deprivation (Jarvik, 1967).

However, the relation of smoking to eating and body weight is not only that of a substitute oral activity. Apart from a possible central action of nicotine as an appetite suppressant, it seems that smoking gives rise to a number of metabolic changes. Smokers tend to weigh less than non-smokers, despite the fact that they eat more. In one study (Lincoln, 1969) the smokers weighed on average 6.5 lb. less

while taking in 350 calories a day more than the non-smokers. Gain in weight, so commonly observed after giving up smoking, is not only a result of increase in eating but tends to occur even though calorie intake is reduced. Cessation of smoking is followed by a fall in serum protein-bound iodine, a drop in oxygen consumption and changes in carbohydrate metabolism (Glauser *et al.*, 1970). These changes may be partly responsible for the tendency to put on weight. Furthermore, it takes about a year before the calorie-intake/weight ratio of the ex-smoker approaches that of the non-smoker (Lincoln, 1969).

As with genetic factors, personality contributes little to the acquisition of smoking, but there is some evidence that it may contribute more to the ability to overcome the habit (Weatherley, 1965; Burns, 1969; Schwartz & Dubitzky, 1968).

Social factors. These are far and away the dominating influence in the acquisition of smoking behaviour and are second only to pharmacological factors in maintaining the habit.

It is well-known that smoking is more prevalent in men than in women—69 per cent as opposed to 43 per cent in the United Kingdom in 1968 (Todd, 1969). However, over the past 30 years the gap has been closing. Women are not only taking up smoking in greater numbers but they are starting at an earlier age than before (McKennell & Thomas, 1967). This transformation of women's smoking behaviour, coinciding with the changing role of women and the attitude of society towards women smokers, provides a striking example of the influence of social factors. It is mostly during the formative adolescent years that women have been influenced by this change in social climate. Those who were already mature were less likely to take up smoking in response to the permissive atmosphere. Thus while some 50 per cent of 20- to 50-year-old women smoke, only 24 per cent of those over 60 years smoke (Todd, 1969). This difference is only slightly contaminated by the greater tendency

for people to stop smoking with increasing age, and is not evident in the case of men where the smoking prevalence is 69 per cent for 20- to 50-year-olds as well as for those over 60 years.

A fairly consistent picture of important social factors is emerging from successive studies. Social class, parental example and precept, older sibling and peer smoking habits, type of school, academic achievement, church attendance, drinking habits are all related to smoking prevalence (McKennell & Thomas, 1967; Salber & Abelin, 1967; Bynner, 1969; Horn *et al.*, 1959). The act of leaving school has a profound effect on increasing smoking. Fifteen-year-olds who have left school are more than twice as likely to be smokers as those still at school (Todd, 1969). This association, however, is partly due to other variables (e.g. low social class, inferior school, poor academic achievement) which predispose to early school-leaving as well as to smoking.

Taking a number of the social factors into account, the hypothetical archetype of the English smoker would be a lower working-class male, aged 25-30, educated at a secondary modern school which he left at 15. He would have grown up in a family of smokers where little effort was made to dissuade him. He would prefer chasing girls and regular drinking with smoking friends rather than going to church. Such a person would have about a 95 per cent chance of being a smoker as opposed to his contratype with a loading of about 10 per cent.

Sensorimotor factors. Clearly there are some smokers who do not smoke for the pharmacological effect alone. This is probably the case with most non-inhalers (9 and 19 per cent respectively of male and female cigarette smokers; Todd, 1969) though some nicotine is absorbed through the buccal mucosa (Kershbaum *et al.*, 1967a). For such smokers it is the performance of the smoking act itself that forms the basis of the habit. The appearance of the packet, the feel of the cigarette, the process of lighting, drawing in, puffing

out and watching the smoke; the smell, the taste, the sound, all contribute to the formation of this elaborate sensorimotor act. One study showed that just over 11 per cent of smokers consider this aspect of smoking important to them (Ikard *et al.*, 1969).

Habitual repetition of the smoking act may be triggered off by a variety of internal and external cues. The particular motivations and rewards no doubt vary with the individual and depend upon the associations of past experience. New associations may be added as old ones fall away (extinguished). For example, initial use as a social prop or symbol of adulthood may be less relevant as social confidence rises and maturity is realized, but with continued use on pleasant relaxing occasions it is likely that the act itself will by association become imbued with some of these qualities. The effect of nicotine may provide positive reinforcement, but for some smokers it is the repetition of the act itself that is gratifying (Horn, 1969). This is especially evident in pipe smokers, where an extended cleaning, filling and lighting ritual may end with no more than one or two non-inhaled puffs. Even with powerfully addictive drugs like heroin the sensorimotor component of 'cooking up' (heating and dissolving the drug in a spoon of water) and injecting can be almost as satisfying as the pharmacological effect (Glatt *et al.*, 1967).

Some current ethological interpretations of human behaviour have likened the hand-shaking, back-slapping and rather stereotyped 'greeting and departure' talk that characterizes social encounters to the grooming behaviour of other primates which is held to have a fear- and aggression-reducing function (Morris, 1967, p. 204; Van Hooff, 1962). The social taboo on physical contact in non-intimate situations that prevails in our culture today rather restricts any instinctual proclivity we may have for grooming behaviour or its equivalent. The social use of smoking, especially if cigarettes are offered and accepted, may provide just such a grooming function. The traditional American Indian

use of the 'pipe of peace' provides some cross-cultural supportive evidence for this suggestion.

Pharmacological factors. In the earlier discussion of the history of tobacco use and the nature of cigarette dependence, the overriding importance of nicotine was emphasized. If it were not for the nicotine in tobacco smoke people would be little more inclined to smoke cigarettes than they are to blow bubbles or light sparklers. Direct evidence of the role of nicotine in determining smoking behaviour is provided by a study which showed that intravenous nicotine significantly reduced cigarette consumption compared with saline control (Lucchesi *et al.*, 1967).

There is not the space to discuss all the complex pharmacological actions of nicotine. It has been known for a long time that its overall effect on the balance of activity in the peripheral autonomic nervous system may be stimulant or depressant according to the dose. Cigarette smoking allows the absorption of about 50–150 μg nicotine per puff or 1–2 mgm per cigarette (Triggs, 1967; Armitage *et al.*, 1968). The peripheral effects of these smoking doses are predominantly stimulant in humans, whether taken by aerosol (Herxheimer *et al.*, 1967), intravenous injection (Makin, 1968) or indeed by cigarette smoking (Irving & Yamamoto, 1963; Lucchesi *et al.*, 1967) and result in a rise in pulse rate, cardiac output and systolic blood pressure. Further stimulation is obtained from the increased output of adrenaline, noradrenaline and hydrocortisone caused by smoking (Kershbaum *et al.*, 1967b, 1968). But it is not only peripherally that smoking stimulates. There is a great deal of evidence that the main effect of smoking doses of nicotine on the brain is to increase the level of arousal (Domino, 1967; Murphree *et al.*, 1967; Armitage *et al.*, 1968, 1969). It is uncertain how much of this effect is direct and how much is mediated via release of acetylcholine, noradrenaline and other biogenic amines. But the effect of nicotine on the central nervous system is not one of straight-

forward stimulation. There may be an ensuing sedative action, especially with larger doses (Domino, 1967; Armitage *et al.*, 1969). Furthermore, for a given dose part of the brain may be stimulated while another part is depressed (Goldstein *et al.*, 1967). Animal experiments show that nicotine tends to facilitate conditioning (Bovet *et al.*, 1967; Armitage *et al.*, 1968) unless excessive doses are used, but only very minor changes on human performance have been demonstrated (Warwick & Eysenck, 1968). Another effect is the clear-cut depression of the patella reflex and electromyographic activity following cigarette smoking, especially of high-nicotine cigarettes (Domino & von Baumgarten, 1969). All these varied responses to nicotine show considerable individual variation in man and animals, but in general neuropharmacological studies provide some support for the apparently contradictory claims of smokers who find cigarette smoking both relaxing and stimulating.

Given its many and varied actions, what is it about nicotine that gives it such dependence-producing potency? In general, to train animals to do things they must be rewarded with something good (e.g. food, water, warmth) or threatened with something bad (e.g. electric shock). Monkeys can be trained to self-inject nicotine for its own sake (Deneau & Inoki, 1967). Nicotine must therefore be in some way intrinsically rewarding. This is probably due to some aspect of its pharmacological effect on the central nervous system. This quality of acting as a primary but 'unnatural' reinforcer of behaviour is shared with other dependence-producing drugs (e.g. opiates, barbiturates, alcohol, caffeine, cocaine, amphetamine). It is not, however, a general characteristic of all potent psychoactive drugs and does not occur, for example, with chlorpromazine or the tricyclic antidepressants (Deneau, 1969). It appears to be a basic property of the dependence-producing drugs. It is still not known to what extent the pharmacological effects of these drugs are directly rewarding, or whether they are

rewarding only because they allay negative withdrawal feelings. This is likely to vary with the individual, the drug, the dose and the degree of dependence. With regular dependent smoking the predominant drive is probably the easing of unpleasant withdrawal feelings, but some smokers no doubt obtain positive reward from the stimulant or tranquillizing effects of nicotine. As with intravenous drugs, the rapid absorption through the lungs provides an almost instant reinforcement which facilitates conditioning compared with the slower effect of drugs taken by mouth.

Experiments with animals have shown that they are not motivated to press a bar that fires an electrode situated in one of the cerebral hemispheres, but if the electrode is placed in a certain part of the hypothalamus (medial forebrain bundle region of the lateral hypothalamus) the animal will spend its waking hours pressing the bar rapidly and persistently (Olds *et al.*, 1960; Olds, 1962). It will do nothing else. It will ignore food, water and sexual activity in favour of inducing electrical activity in this one part of the brain. It seems reasonable to regard this area as a 'pleasure centre'. Control of all the primary drives (e.g. sex, hunger, thirst, temperature regulation) is centred on the hypothalamus. Successive activation and gratification of these drives is likely to influence the nearby pleasure centre and thereby affect our sense of well-being or 'hedonic tone'. There are probably many influences that determine whether at any one moment we are experiencing positive or negative hedonic tone or affect. Certainly the level of nicotine in the brain is crucial for the highly dependent smoker. The blood-brain barrier is no barrier to nicotine. On the basis of animal studies (Schmitterl w *et al.*, 1967) it is probable that nicotine is present in the brain, including the hypothalamus, within a minute or two of beginning to smoke, but by as little as 20-30 minutes after completing the cigarette most of this nicotine has left the brain for other organs (e.g. liver, kidneys, stomach). This is just about the period when

the dependent smoker needs another cigarette. The smoking pattern of the dependent smoker who inhales a cigarette every 30 minutes of his waking life is such as to ensure the maintenance of a high level of nicotine in his brain. While they are not quite as potent as self-stimulation with an implanted electrode, it is likely that the special feature of dependence-producing potential possessed by some psychoactive drugs (including nicotine) rests in their pharmacological ability to either directly or indirectly influence the hypothalamic reward system.

THE ONSET OF SMOKING

Given that smoking depends on a complicated interaction of personal, social and pharmacological factors, it is necessary to study the natural history of the behaviour to understand the quite distinct processes of acquisition, maintenance and cessation. In other words, we need to know why people start, why they continue and why they stop smoking. The acquisition of smoking is a phenomenon of adolescence, but for some it starts before the age of 10. After 3 or 4 years of intermittent smoking, regular adult-type dependent smoking sets in. It has already been described how it takes no more than a few cigarettes to start an almost inevitable escalation. It is only the teenager who never attempts, or who has attempted no more than once and decided that he dislikes it and will not take it up, who has much chance of being a non-smoking adult (McKennell & Thomas, 1967; Salber & Abelin, 1967). The matter is largely settled by the age of 20; if a person is still a non-smoker at this age he is unlikely to take it up (McKennell & Thomas, 1967; McKennell, 1969).

The reasons most people give for their first experiments with smoking are curiosity, conformity, bravado or to appear grown-up (Horn *et al.*, 1959; Salber *et al.*, 1963). The first few cigarettes are almost invariably unpleasant. But tolerance soon develops to the unpleasant side-effects and skill is quickly

acquired to limit the intake of smoke to a comfortable level, thus lowering the threshold for further attempts. Herein lies a possible cause of the virtual inevitability of escalation after only a few cigarettes. With curiosity satisfied by the first cigarette, the act is likely to be repeated only if the physical discomfort is outweighed by the psychological or social rewards. If these motives are sufficient to cause smoking to be repeated in the face of unpleasant side-effects, there is little chance that smoking will not continue as these side-effects rapidly disappear. What is the nature of these psychological and social pressures to smoke? The social factors have been mentioned already in the discussion of the causes of smoking, but the evidence is derived mainly from cross-sectional correlation studies which give little insight into how these influences act on the individual. One prospective study does indicate that the dissuasive influence of parents' attitude and health education operate early and are largely ineffective after the age of 15 years (Salber & Abelin, 1967).

A great step forward in understanding the process of beginning to smoke has been made possible by Bynner's outstanding survey of 5601 10- to 15-year-old schoolboys in England and Wales (1969). Computerized discriminant function analysis revealed that recruitment to smoking depended largely on four main influences: (i) 'number of friends who smoke', (ii) 'anticipation of adulthood', (iii) 'parents' permissiveness towards smoking', (iv) 'whether put off smoking by the danger of lung cancer'. The discriminant power of these influences was so great that where all four were together favouring smoking 70 per cent of boys were in fact smokers, whereas there were no smokers at all among those in whom all four influences were negative. The number of friends who smoked was the most powerful single influence; for example, there were no smokers among boys who said that none of their friends smoked, compared with 62 per cent of smokers among boys who said that all their friends smoked. An interesting

fact to emerge was that 'rebelliousness' and 'delinquency', though correlated with smoking (0.39 and 0.38 respectively) did not appear to have a direct influence but were rather associates of the more powerful determinant, 'anticipation of adulthood'. This variable involved participation in the activities of older boys such as going out drinking, driving a car, going to coffee bars, dances and staying out late.

Another study (Schofield, 1965) revealed an association in English teenagers between sexual experience and cigarette smoking ($P < 0.001$). This was particularly striking in the girls, where over 90 per cent of those who smoked over 20 cigarettes a day had had sexual intercourse, compared with 16 per cent of the rest of the sample. It is not suggested that this correlation is causal, but it seems that early sexual experience, like smoking, tends to occur in a setting of low social class, poor school achievement, early school leaving, and early participation in the out-of-school culture of older teenagers.

Schoolboys who smoke perceive themselves and are perceived by others as lacking educational success compared with non-smokers (Bynner, 1969; McKennell & Bynner, 1969). Furthermore, this image is substantially correct (Bynner, 1969; Salber & Abelin, 1967; Mausner & Mischler, 1967; Horn *et al.*, 1959). They may consequently be more drawn to compensate their self-esteem by smoking, which is regarded as symbolic of 'toughness' and 'precocity' both by smokers and non-smokers (Bynner, 1969; McKennell & Bynner, 1969). This trend is confirmed by another study which showed that young people viewed smokers as being 'adventurous' and 'lacking timidity' (Weir, 1967). For boys, smoking may also symbolize 'masculinity' and 'male identification', as they are very likely to adopt their father's smoking example (McKennell, 1969).

Why some boys are more attracted than others to the image of social maturity, toughness and masculinity imparted by smoking may in some cases be explained in the follow-

ing way. Most school environments are dominated by the adult-imposed middle-class orientated school ethic. This is epitomized by the head-boy hero-type who is good at work and games, respected and popular with peers, teachers and parents alike. Such a boy is geared to 'A' levels, university and successful upper middle-class adult status. With these long-term goals in view, he is in the main content with the schoolboy role which includes not smoking. On the other hand, those who are or perceive themselves to be failing to achieve educational success, without which all the long-term rewards of the value system are blocked, are forced to adopt an alternative strategy. A few may compensate by prowess at sport, but for many the only way to achieve status in the eyes of their more successful schoolmates (or find it in a different value system) is to join in the out-of-school culture of older boys. This involves chasing girls, going to cafés, cinemas and dances, spending money on clothes and pop records. It is an environment of smokers; to gain acceptance and feel confident within it the social pressures to smoke are overwhelming and the symbolic value of social maturity, toughness and masculinity provided by the cigarette has obvious relevance. All this is done while school-orientated peers occupy themselves with less precocious activities, such as homework, reading, watching television, or at hobbies like woodwork, cycling and looking after pets; in an environment where there are few smokers, where the symbolic value of smoking is less meaningful, and where the pressures are against rather than for smoking (Bynner, 1969). Thus it is those who lack educational and school success who are not only in greater need of the psychological rewards provided by smoking but who are also forced into an environment of smokers in which they are exposed to the most powerful of Bynner's social influences, namely the number of friends who smoke. In this way the onset of smoking is predominantly mediated by social and psychological factors acting on the school-going child.

THE MAINTENANCE OF SMOKING

In the early stages, subtle interplay of social and psychological pressures cause the smoking act to be repeated. As consumption rises and inhalation deepens, pharmacological rewards are added. Smoking ceases to be confined to social situations and occurs with increasing regularity. Withdrawal causes subjective malaise and craving. This is instantly relieved by smoking, thereby ensuring repeated reinforcement and strengthening of the habit to a stage of dependence. By these means the young smoker is unconsciously conditioned and shaped to his particular pattern of smoking behaviour. The early motivations are thus gradually replaced by the pharmacological rewards of nicotine which are largely responsible for the maintenance of smoking, though they are aided to some extent by the persistence of social influences. In other words, the reason why most adults continue smoking is essentially that they have become dependent on nicotine. The fact that smoking is pursued in the face of considerable health and financial disincentives points to the strength of this dependence.

Using a short questionnaire, American experts have suggested a way of categorizing smokers (Horn-Tomkins typology) according to their scores on six factors (substantiated by factor analysis) representing gratifications derived from smoking (Tomkins, 1968; Ikard *et al.*, 1969). Three factors—'stimulation', 'sensorimotor manipulation', 'pleasurable relaxation'—reflect the positive rewards of smoking (positive affect smoking). The fourth factor, 'reduction of negative feelings', indicates the use of smoking as a tranquillizer to allay unpleasant feelings of anxiety, tension, anger, etc. (negative-affect smoking). The remaining two factors are 'psychological addiction' and 'habituation'. The 'addictive smoker' is always aware of not smoking whenever this occurs. The 'habitual smoker' is supposed to smoke automatically and not to miss a cigarette if one is not available. A pure type is rare and most smokers are moti-

vated by varying proportions of several of the six factors. There was considerable correlation (0.58) between 'addictive' and 'negative affect' smoking, which suggests that much of the negative affect may be a withdrawal effect.

In a major British study (McKennell & Thomas, 1967; McKennell, 1970) smokers were classified according to the occasions on which they were likely or unlikely to smoke. Replies to a checklist of occasions for smoking were subjected to factor analysis. The following seven types of smoking situation emerged: 'nervous irritation', 'relaxation smoking', 'smoking alone', 'activity accompaniment', 'food substitution', 'social smoking', 'social confidence'. There was high correlation between the first five smoking situations, which were collectively termed an 'inner need factor', while the last two factors went together as an overall 'social factor'. Thus the empirically derived McKennell-Thomas typology reveals two broad categories of smoker: those whose smoking seems to be motivated by 'inner needs' and those in whom a 'social' factor is dominant. There is little overlap between these two factors. The 'inner need factor' is positively correlated with cigarette consumption, withdrawal craving and the age of the smoker. The 'social factor' is largely independent of amount smoked and withdrawal craving and is a feature of adolescent rather than adult smokers. These findings provide some support for the view expressed above that social forces acting on children are the main determinants of the onset of smoking, while the regular dependent adult smoking pattern is largely maintained by 'inner need' factors which can be equated with pharmacological factors. The 'inner need' is mainly for nicotine and is in most cases not satisfied by smoking a nicotine-free cigarette.

THE NATURAL DISCONTINUANCE OF SMOKING

In discussing the natural history of smoking it has been pointed out that how it starts is a

different process from how it is maintained. This differs again from its cessation. In the 10-year period 1958-68 there was little change in smoking prevalence among men in the United Kingdom—about 69 per cent were smokers, 15 per cent ex-smokers and 16 per cent had never smoked (Todd, 1969). In such a sample the ex-smokers form 18 per cent of the smokers and ex-smokers combined ($15 \times 100 / [15 + 69] = 17.86$). Using the 1968 statistics for women, a similar figure is obtained ($9 \times 100 / [9 + 43] = 17.3$). Thus some 18 per cent of smokers have stopped smoking and become ex-smokers. This so-called natural discontinuance of smoking tends to occur after the age of 30 and rises further with increasing age (McKennell & Thomas, 1967; Todd, 1969; Hammond & Garfinkel, 1964, 1968). The average daily cigarette consumption also tends to drop quite sharply after the age of sixty. The ex-smoker status, however, is not a stable one and many relapse to regular smoking. This relapse rate is related to the duration of the ex-smoker status. Among ex-smokers of less than 1 year's standing 37 per cent relapse within two years compared with 19 per cent of those with 1-2 years' standing and 5 per cent of those with over 2 years' standing (Hammond & Garfinkel, 1964). There is therefore a sizable dynamic turnover, with regular smokers discontinuing only to relapse later. The evidence suggests that in the present social climate of this country it is unlikely that more than 15 per cent of people who smoke regularly undergo natural discontinuance to permanent ex-smoking status before the age of 60 (Todd, 1969). Furthermore, this situation has not changed appreciably over the past 10 years.

McKennell & Thomas (1967) have developed the useful concept of 'dissonant' and 'consonant' smokers. Dissonant smokers are those with negative attitudes towards smoking who would like to and may have tried to give up. Consonant smokers are outwardly happy about their smoking and have no wish to stop, though they may have tried in the past.

Each group comprises about half the smoking population. While dissonant smokers are the ones who wish to give up, as a group they are also the more dependent. Ex-smokers tend to resemble consonant smokers in having a low rating on dependence, but have unfavourable attitudes to smoking similar to dissonant smokers. These findings have led to the suggestion that *ex-smokers are recruited predominantly from consonant smokers, whose attitudes to smoking change in response to some social factor such as changing to a job where smoking is not allowed or acquiring a new circle of non-smoking friends* (McKennell & Thomas, 1967).

Put another way this means that if a person is only mildly dependent, an attitude change will be followed by appropriate behaviour change, whereas with a higher degree of dependence, smoking does not stop and a dissonant smoker rather than an ex-smoker is created. Another sequence may occur: a *consonant smoker may change his attitude, try to give up smoking, fail because of too high a degree of dependence, but rather than maintain a dissonant attitude he reverts to a more comfortable consonant one*. This sequence probably underlies the 40 per cent of consonant smokers who actually tried stopping in the past though they no longer wish to stop (McKennell & Thomas, 1967). This deduction is supported by the fact that this group of consonant smokers have higher ratings on dependence and 'inner need' factors (more in line with those of dissonant smokers) than the 60 per cent of consonant smokers who have never tried to stop.

Though no more than 25 per cent of smokers eventually do stop permanently, 77 per cent of current smokers wish to stop or have tried unsuccessfully (McKennell & Thomas, 1967). The reasons for discontinuance, given by successful ex-smokers and smokers who wish to stop, fall into six themes (Horn, 1969; McKennell & Thomas, 1967; Trahair, 1967). (i) *Health*: a host of lesser ailments, which include cough, breathlessness, sore throat and indigestion, are far more

important than the more dramatic risk of cancer in motivating the individual smoker to stop. This is probably because it is usually only when he reaches the stage of personally experiencing one of these health ailments that the smoker is finally motivated to stop. The increase in physical ailments that occurs with age may account for the greater tendency for *older rather than young people to stop smoking*. (ii) *Expense*: this is second only to minor health ailments as a motive for adults to stop smoking, but for adolescents it is the prime reason (McKennell & Thomas, 1967). (iii) *Social influences*: pressure from other people is third in importance for adults and teenagers. (iv) *Example*: this involves doctors, parents and teachers who do not wish to lead children into smoking. (v) *Mastery*: a test of will-power or a dislike of being unable to control the habit. (vi) *Aesthetics*: a belief that smoking is nasty and dirty. These last three motives are of relatively minor importance.

It is not clear why so many fail to stop successfully. *None of the motives for stopping are able to differentiate those who succeed from those who fail*. Some probably succeed because they are not strongly dependent, others because they are capable of considerable cognitive self-control. On Edwards' Personal Preference Schedule testing, ex-smokers tend to show low 'affiliation', low 'change' and high 'achievement', indicating a stable personality with high drive to overcome difficult tasks, an ability to stick to decisions and little need of close ties with smoking peers (Weatherley, 1965). Other studies suggest that neurotic subjects are less likely to be successful (Burns, 1969; Schwartz & Dubitzky, 1968). A social environment that is not too conducive to relapse is doubtless an important contributory factor.

Cigarette smoking is clearly a habit that is easily acquired but difficult to break. If we bear in mind that only 15 per cent of adolescents who smoke more than one cigarette avoid becoming regular smokers and that only about 15 per cent of smokers stop before the age of 60, it becomes apparent that of those who

smoke more than a single cigarette during adolescence, some 70 per cent continue smoking for the next 40 years. Cocteau's dictum, 'He who has smoked will smoke', is as pertinent to tobacco smoking now as it was to the smoking of opium in his time.

SUMMARY

A case is made for regarding cigarette smoking as a dependence disorder that is statistically linked with dependence on alcohol and other drugs. The dependence-producing potential of smoking is currently greater than that of alcohol and barbiturates in that most smokers are dependent smokers, whereas a majority are able to use alcohol and barbiturates intermittently and sensibly. It is only the exceptional 2 per cent who smoke occasionally and intermittently who are truly non-dependent smokers. Furthermore, dependence on smoking can no longer be regarded as 'merely psychological'; most cigarette smokers probably fulfil the criteria for physiological dependence on nicotine, namely tolerance and physical withdrawal effects.

The onset of smoking is determined by the interaction of social and psychological factors during adolescence. It takes no more than three

or four casual cigarettes in this sensitive period virtually to ensure evolution to regular dependent smoking within a few years. Only about 15 per cent of those who have more than one cigarette avoid becoming regular smokers. The matter is largely settled by the age of 20: if a person is a non-smoker at this age, he is unlikely to take it up.

Established smoking is primarily maintained by dependence on the pharmacological effects of nicotine, which are predominantly stimulant but may also be sedative. Eventually, when some of the ill effects of smoking on health are already being experienced, most smokers try to stop, but only about 15 per cent succeed before the age of 60.

Cigarette smoking is clearly a habit that is easily acquired but difficult to break. In the prevailing social climate, of those who smoke more than a single cigarette during adolescence, some 70 per cent continue smoking for the next 40 years.

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An experimental technique for the study of unconscious conflict

By LLOYD H. SILVERMAN*

Psychoanalytic theory views psychopathology as a response to and an expression of unconscious conflict. More specifically, the theory proposes that such pathology occurs in reaction to the pressure of unacceptable 'drive derivatives', i.e. ideational and affective components of libidinal and aggressive drives. Since these threaten the individual with the arousal of traumatic anxiety, he tries to ward off these derivatives by utilizing various defensive operations. Sometimes these operations are successful, having no or minimal maladaptive consequences, while on other occasions they are unsuccessful in that the unwanted drive derivatives, the anxiety, or both, emerge anyway; or more complex pathological phenomena, e.g. phobias, obsessions and conversions, appear instead.†

This view of psychopathology has by no means been adopted by all workers in the mental health professions. Behaviour therapists, for example, conceive of the same phenomena as 'faulty habits' (cf. Wolpe, 1958) and others (e.g. Fromm, 1947; Rogers, 1951) view them as the outcome of failures in self-actualization. Since these varying conceptions have led to different therapeutic approaches, it is of more than academic interest that so little *experimental* research has been carried out that bears on this fundamental psychoanalytic view. This contrasts with the fact that a number of *correlational* studies have been undertaken, in which attempts have been made to relate the degree to which particular drive derivatives,

anxieties or defence mechanisms are present with the appearance of particular pathological manifestations (e.g. Caine, 1960; Klaber, 1960; Welch *et al.*, 1961). But since correlational data can at best only be viewed as *consistent* with a particular viewpoint, rather than as directly supportive of it, it is hardly surprising that exponents of opposing schools of thought have not felt uneasy in rejecting the psychoanalytic position.

The absence of relevant experimental data bearing on the psychoanalytic view of psychopathology can be attributed mainly, in my opinion, to the lack of a technique for experimentally manipulating unconscious conflict. The problem posed for research has been to find a way of stirring up drive derivatives *without disturbing their status as unconscious phenomena*. For it would follow from psychoanalytic thinking that should these derivatives emerge as conscious wishes, their link to pathology would be severed. Gross behavioural manipulations (e.g. provoking an individual so as to stir up aggression) would not be the method of choice, since it is possible, perhaps even likely, that the emerging drive derivatives will take the form of a conscious impulse, which according to the theory would make it unlikely that a pathological response would ensue.*

The technique that we have developed to meet this problem involves the tachistoscopic presentation of drive-related stimuli at a *subliminal* level. When we began our work in the early 1960s, we reasoned that if the proponents of subliminal registration were

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† This is a highly condensed and simplified statement of the psychoanalytic position. For an extended up-to-date discussion, see Rangell (1963).

* With regard to aggression, for example, the psychoanalytic theoreticians Hartmann *et al.* (1949) have stated: 'objective danger is one situation that allows for and invites a discharge of aggression [and] is *less* likely to lead to pathological responses' (p. 23, *italics mine*).

correct, one could capitalize on such registration for stirring up drive derivatives outside of awareness. That is to say, a stimulus containing drive properties, when perceived subliminally, first should make contact with derivatives of the related drive that are currently active in the individual. Then, in line with what researchers in this area have reported occurs after subliminal registration of any stimulus (cf. Pine, 1964), the emerging drive-related ideas and images are likely to be *transformed*, so that their drive-related character is obscured. This, we thought, would be the case particularly for those individuals in whom the drive was unacceptable in the first place, and this would include those whose psychopathology was based on that drive. For them it seemed especially unlikely that the drive derivatives would gain access to awareness, let alone be experienced in the form of a conscious impulse. Instead the derivatives could be expected to press for expression without the person's awareness; and it is in just such a circumstance that psychoanalytic theory postulates that pathology can ensue.

In 13 studies completed in our laboratory to date, this expectation has been borne out.* The subliminal presentation of a drive-related stimulus produced pathological reactions which did not appear either after the subliminal presentation of a neutral stimulus or after the same drive-related stimulus was presented in awareness. In light of the relevance such data have for the psychoanalytic theory of psychopathology and the challenge that we believe they pose for other theories, I should like to take this occasion to summarize and briefly discuss these findings.

The particular relationship between drive

* Silverman (1965, 1966), Silverman & Candell (1969, 1970), Silverman & Goldweber (1966), Silverman & Gordon (1969), Silverman & D. K. Silverman (1964), Silverman & S. E. Silverman (1967), Silverman & Spiro (1967, 1968), Silverman *et al.* (1969), S. E. Silverman (1969), Spiro & Silverman (1969).

and psychopathology that the great majority of the studies have focused on is that between aggression and what we have termed 'pathological thinking' and 'pathological non-verbal behaviour'.* Referred to here is thinking and behaviour that can be judged to be out of keeping with the usual requirements of logic and reality considerations, thus being viewed by others as inappropriate and strange. According to the usual psychiatric nomenclature, when they appear in their more extreme forms such manifestations warrant the label 'psychotic', and are considered particularly characteristic of schizophrenic conditions. Since we wished to study these phenomena in subjects who were most prone to manifest them, most of our studies utilized psychiatric patients with a diagnosis of schizophrenia; but since certain of these pathological manifestations also occur in non-schizophrenics, we studied two other groups of individuals as well.

Turning first to the investigations utilizing schizophrenics, we have completed 10 studies on patients with this diagnosis and two other studies have been carried out by independent investigators seeking to replicate our findings. In all of our investigations the basic experimental design has been the same and this will now be described.

METHOD

Subjects are seen individually for an 'aggressive session' on one day and a 'control session' on another. On each day, after rapport has been established, a 'baseline' measure of the individual's propensity for pathological manifestations, as defined above, is obtained by administering one or more psychological tests, as they would be given in a clinical situation. In different experiments we have utilized such tests as the Rorschach, a word-association test and a story-recall task for this purpose. Then the subject is

* For a discussion of why we chose to focus on this particular relationship, see Silverman (1967, pp. 382-4). The clinically based formulations of Bak (1954) and Hartmann (1953) were particularly influential in this regard.

asked to look through the eye-piece of a tachistoscope located next to where he is sitting and is told he will now be shown a few flashes of light which he is to describe. Four exposures of either a picture with aggressive content or one with relatively neutral content follow, each for a 4 msec. duration. There then follows a 'critical' series of whatever test or tests were given in the baseline series, this allowing for a determination of how the subjects have been affected by the particular stimulus that has been exposed.

The procedure for the other session is identical with that just described, except that a different picture is exposed between the baseline and critical test series. Subjects who are exposed to the picture with aggressive content in the first session are shown a neutral stimulus in the later session and *vice versa*.* In each session, an assistant inserts the slide with the stimulus on it into the tachistoscope before the experimenter enters the room. Thus the latter who works the tachistoscope and administers the psychological tests never knows which of the stimuli is being exposed. Since the subject is also unaware of the nature of the stimulus (it being subliminal) the procedure can be described as 'double blind' in the same sense as in drug studies where neither the patient nor the person administering the capsule knows whether a drug or a placebo is being ingested. The evaluation of the test protocols for pathological thinking and behaviour is, of course, 'blind' also.

RESULTS

Before summarizing the results of these studies, let me comment briefly on our designation of stimuli as 'subliminal'. Our operational definition of subliminality is an exposure level at which flashes produced by the two stimuli

* In the various experiments different aggressive and neutral pictures have been utilized with essentially the same results. The pairs of experimental and control stimuli that have been used have included a snarling man with a dagger in his upraised hand *v.* a man reading a newspaper; a growling tiger chasing a monkey *v.* two playful looking beagles; a roaring lion charging *v.* a bird flying; and a man with teeth bared attacking a woman *v.* two bland-looking men.

cannot successfully be differentiated from each other. This determination is made at the end of each experiment when a 'discrimination task' is administered to the subjects in which the experimental and control stimuli are presented randomly under the same tachistoscopic conditions as they were in the experiment proper and the subject's task is to tell them apart. Elsewhere (Silverman & Spiro, 1967*b*; Silverman, 1968) these findings are summarized, together with a detailed discussion of how these data and other evidence that is presented warrant, in our opinion, the designation 'subliminal'. However, from the standpoint of the current focus on the psychoanalytically posited relationship between unconscious drives and psychopathology, it hardly matters whether everyone would agree that *his* criteria for subliminality have been met by the conditions of our experiments. Suffice it to say here that, as will be detailed shortly, when our experimental and control stimuli have been exposed at a *supraliminal* level, the results which will now be summarized have not been obtained.

In all 10 investigations of schizophrenics carried out in our laboratory, subliminal aggressive stimulation was found to intensify pathological thinking, pathological non-verbal behaviour, or both. In a recent re-examination of these data, it was discovered that typically this pathology emerged as a *delayed* effect. In almost all of the studies mentioned the effects of the stimulation have been sought on two tasks, and while the intensified pathology appeared only occasionally during the earlier one administered, it regularly emerged on the second task. Table 1 summarizes these findings. A rather involved explanation for this delayed effect can be found elsewhere (Silverman & Candell, 1970); here it is noted as a variable, the knowledge of which allows for a more precise specification of the conditions under which our experimental manipulation produces pathology. Another such variable appears to be the length of time the schizophrenic has been hospitalized. As Table 1 illustrates, the

aggressive stimulation produced a considerably broader effect in the samples of long-term patients than in the short-term samples studied; broader in the sense that the pathology was more apt to emerge in both the thinking and non-verbal behaviour realms and its emergence was less apt to be limited to the later task administered. We have attributed this difference to the generally held assumption that short-term schizophrenics have more ego resources available

presentation of three verbal stimuli and three pictorial stimuli. One of each contained 'oral-aggressive' content (a verbal message 'cannibal eats person' and a picture showing such a scene); and one of each contained aggressive non-oral content (verbal message 'murderer stabs victim' and a picture depicting this). Comparing each of the aggressive stimuli with its control, he found that the oral-aggressive stimuli significantly increased pathological thinking, but the aggressive non-

Table 1. *Summary of results from studies comparing the effects of subliminal aggressive and subliminal neutral stimulation*

Study	n	Length of hospitalization status of schizophrenic subjects†	T values for initial results		T values for delayed results	
			Pathological thinking	Pathological non-verbal behaviour	Pathological thinking	Pathological non-verbal behaviour
Silverman (1966)	32	Long-term	< 1	+1.73*	+1.90*	+2.61**
Silverman & S. E. Silverman (1967)	30	Long-term	+1.25	< 1	+1.66	+2.02*
Silverman & Spiro (1967a)	40	Long-term	+2.66*	< 1	+2.19*	< 1
Silverman & Spiro (1968)	32	Long-term	+1.78*	< 1	+2.20*	+1.80*
S. E. Silverman (1969)	48	Long-term	‡	+3.79***	+1.86*	+4.12**
Silverman <i>et al.</i> (1969)	52	Short-term	< 1	< 1	+2.45**	< 1
Silverman & Candell (1969)	36	Short-term	+1.57	< 1	+2.81***	< 1
Silverman & Candell (1970)	30	Short-term	< 1	< 1	< 1	+2.58†
Silverman & Gordon (1969)	36	Short-term	< 1	< 1	< 1	+2.44†
Spiro & Silverman (1969)	32	Short-term	< 1	< 1	< 1	+2.48†

* $P < 0.05$. ** $P < 0.01$. *** $P < 0.005$.

† 'Long-term' schizophrenics are those who have been hospitalized for more than six years, while 'short-term' patients have had less than three years of hospitalization. The status reported for each sample is that of the great majority, though not all of the subjects.

‡ In this study no early test was given which yielded a measure of pathological thinking.

to them than do long-term patients and thus are more able to fend off the encroachment of pathology (Silverman & Candell, 1970).

Further specification of the conditions under which subliminal aggressive stimulation increases pathology in schizophrenia has been made possible by the two independent investigations which have sought to replicate our findings. In one of these Lomangino (1969) utilized the tachistoscopic procedure that has been used in our laboratory and compared the effects of the subliminal

oral stimuli did not. This finding both was consonant with clinical psychoanalytic reports on the strong oral-incorporative component in the schizophrenic's aggression (e.g. Pious, 1949) and was consistent with our past results since each of the experimental stimuli we have used in our studies contained an oral-aggressive element (see descriptions in earlier footnote). Lomangino also found that the verbal oral-aggressive stimulus was as effective as the pictorial one, a result that interests us for two reasons. First, it suggests that the

axiomatic idea that pictures have more of an impact on an individual than words does not apply to the subliminal registration of drive stimuli, a conclusion that more recently collected data from our laboratory also support. It is consistent with our assumption that a subliminal drive-related stimulus, rather than *arousing* an affect (which pictures undoubtedly are better able to do than equivalent words), merely *triggers* emotions—as well as ideas and images—that already are active in the individual. (See Silverman, 1967, for a discussion of 'triggering' and the manner in which we understand a subliminal drive-related stimulus to operate.) Second, verbal messages that are equal in effectiveness to pictures have methodological advantages which we intend to exploit in future studies. They are more capable than pictures of communicating a wide range of content in a relatively unambiguous and precise way.

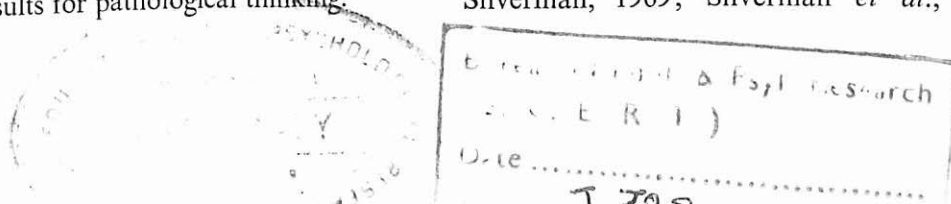
The other replication was carried out by Buchholz (1968) as part of a larger investigation of the effects of drive stimulation on schizophrenic functioning. She, too, found a significant increase in pathological thinking* after subliminal aggressive stimulation, and what was of special interest here was that her subliminal presentations were auditory rather than visual. Thus it appears that the former kind of input, as well as the latter, is capable of triggering drive derivatives.

In two of our studies (Silverman, 1965; Silverman & Goldweber, 1966) we investigated whether the relationship between pathological manifestations and aggression holds for persons who are not schizophrenic as well as for those who are. In the first of these (Silverman, 1965) two groups of hospital employees screened for the absence of schizophrenia served as subjects. For one group the procedure was identical to that administered to the schizophrenics, but for the other group the subjects were 'primed' for aggression at the beginning of both the experimental

and control sessions. A highly charged aggressive passage was read to the subjects at that time, presented as a memory task. This was intended to arouse aggressive drive derivatives *before* the aggressive subliminal stimulus was presented. The subjects in each group were further divided in terms of whether or not they responded to such an arousal with expressions of relatively *blatant* aggressive imagery. Of the four subgroups of subjects so formed, only one reacted to the subliminal aggressive stimulation with an increase in pathological manifestations as the schizophrenics had done. This was the group that both was primed for aggression and was characterized by blatant imagery prior to the subliminal aggressive stimulation. This finding was later replicated in a second study of hospital employees (Silverman & Goldweber, 1966). These results indicate that the relationship between aggression and pathological manifestations is not unique to schizophrenics. Moreover, it suggests that the preconditions that are necessary for its emergence in non-schizophrenics—a state of aggressive arousal and a tendency to react to such arousal with blatant aggressive imagery—hold *generally* for schizophrenics. This can be considered an important aspect of the latter group's psychology and one that is in keeping with a number of reports from the clinical psychoanalytic literature (e.g. Bak, 1954; Hartmann, 1953; Pious, 1949). (See Silverman, 1967, for a detailed discussion of the relationship between our experimental findings on aggression and psychoanalytic theory.)

Since psychoanalysis implicates libidinal impulses in psychopathology as well as aggressive, we also have introduced into a number of our experiments subliminal libidinal stimuli. While the effects of these have not as yet been studied as thoroughly or systematically as that of subliminal aggressive stimulation, results from four of our experiments (Silverman & D. K. Silverman, 1964; Silverman & S. E. Silverman, 1967; S. E. Silverman, 1969; Silverman *et al.*, 1970)

* Buchholz and Lomangino did not record pathological non-verbal behaviour and only reported results for pathological thinking.



indicate that this stimulation, too, is capable of triggering psychopathology. Two of these studies were ones in which schizophrenics served as subjects (Silverman & S. E. Silverman, 1967; S. E. Silverman, 1969). In these, stimuli intended to stir up voyeuristic and homosexual drive derivatives, while not leading to the kind of pathological thinking and behaviour that appeared in response to aggressive stimulation, *did* result in losses in *efficiency* in performance on intelligence test-type tasks. In our most recently completed investigation (Silverman *et al.*, 1970) stutterers rather than schizophrenics served as subjects, and for each of two groups of persons affected with this speech disorder there was significantly more stuttering after the subliminal presentation of a stimulus with an anal theme (a picture of a dog defaecating) than after subliminal neutral stimulation. This finding was viewed as consonant with one of the psychoanalytic formulations regarding the kind of unconscious impulses that are central to this disturbance (Fenichel, 1945).

Let me turn now to the conditions under which a stimulus conveying drive-related content has been found to trigger psychopathology. Our assumption, as spelled out earlier, was that this was most apt to happen when the content of the stimulus bypasses awareness. We tested this assumption in two of the studies with schizophrenics (Silverman & Spiro, 1968; Silverman & Candell, 1970) and in two studies of non-schizophrenics (Silverman & Goldweber, 1966; Silverman *et al.*, 1970). In all three we found that when the drive stimulus was presented supraliminally and in the subject's awareness, in contrast to what occurred after subliminal drive stimulation, there was no increase in the pathology under consideration. This finding was independently replicated in the study of Lomangino (1969) mentioned earlier.

In two of these studies (Silverman & Goldweber, 1966; Silverman & Spiro, 1968), there were a handful of subjects who gave evidence of blocking awareness of the supraliminally

appearing drive-related content. In both cases, as much pathology appeared for them after this supraliminal condition as appeared after the subliminal drive condition (which was not the case for the great majority of subjects who did not show this blocking tendency). Thus the pathology-inducing effect of the drive stimulus seemed dependent on its drive-related contents being out of awareness—whether because the subject blocked them out or because the subliminal presentation made awareness impossible did not seem to matter. These results have two implications. First, they point to one of the adaptive functions that awareness serves, i.e. it protects the individual against the pathogenic effects of noxious external stimuli. Second, they support the rationale offered earlier for employing the subliminal technique for triggering psychopathology. The subliminal presentation *guarantees* that there will be no awareness of the stimulus' drive-related properties.

Finally, I should like to turn to experimental data emerging from studies that employed the technique described here which bear on the view that under certain circumstances the stirring of unconscious drives can *enhance* adaptation rather than intensifying psychopathology. Psychoanalytically, this can be understood as evolving in at least two ways. First, there are instances in which some real-life occurrence stimulates in an individual an unconscious fantasy which gratifies a dominant ego-alien drive, but without its mobilizing guilt or anxiety. The motivating force of the drive then abates and whatever pathology ordinarily results from the conflict over the drive temporarily remits. Second, there are instances in which individuals find adaptive rather than pathological ways of expressing unconscious drives.

Relevant to the first of these propositions are studies (Silverman *et al.*, 1969; Silverman & Candell, 1970) in which we sought to stir up in the schizophrenic the fantasy that he had established a symbiotic union with his mother. Based on theoretical considerations that are

discussed elsewhere (Silverman *et al.*, 1969; Silverman, 1970) and in keeping with a report by an eminent clinician who has had extensive psychotherapeutic contact with schizophrenics (Searles, 1959), we predicted that the stimulation of such a fantasy would *diminish* pathological manifestations in such patients, i.e. would have an effect just the opposite of aggressive stimulation. For each of three samples of relatively differentiated schizophrenics (total $n = 61$), we contrasted the effects of the subliminal presentation of a 'symbiosis stimulus' (a picture of a man and woman merged together like Siamese twins, accompanied by the verbal message 'Mommy and I are one') with the effects of a neutral stimulus (a picture of two bland-looking men accompanied by the verbal message 'Men talking'). In each sample the schizophrenics reacted to the experimental condition with a reduction in pathological thinking. It can be added that in one of these studies (Silverman & Candell, 1970) when the same symbiosis theme was exposed supraliminally it had no effect on the schizophrenic's pathology, offering further support for our contention that experimental attempts to influence psychopathology can best proceed if the dynamically relevant stimuli bypass awareness.

The validity of the second formulation posited above—that the stirring of drives under some conditions leads the individual to find adaptive rather than pathological ways of responding—was supported in a recent study by Antel (1969). She employed the subliminal technique that has been described in order to study 'creative thinking' in a group

of college English majors. On the Remote Associates Test (RAT) developed by Mednick (1962), as a test of associative freedom and the ability to form connexions among disparate concepts, she found significantly *better* performance after the subliminal exposure of both an aggressive and libidinal stimulus than after subliminal neutral stimulation. In discussing this finding, she states: 'the research further supports and expands the notion that intricate psychic processes and reactions can be stimulated by the subliminal exacerbation of drive derivatives and demonstrates that such drive stimulation has under certain conditions the power of enhancing as well as impairing adaptive functioning' (p. 73).

In addition to the experiments summarized in this paper, mention also can be made of a number of studies that are in progress (as doctoral dissertations) which suggest the range of problems that might be broached with the technique that has been described. These include studies of the unconscious conflicts that have been proposed by psychoanalytic clinicians as underlying such psychological disturbances as depression, drug addiction and homosexuality; and investigations of the unconscious motives that have been postulated as contributing towards such adaptive behaviours as achievement strivings in women, humour and artistic experience. The technique, then, can be viewed as one which can make accessible to the experimental researcher under conditions of controlled observation, the kinds of dynamic interplay between underlying conflict and manifest behaviour with which psychoanalytic theory always has been concerned.

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The home background of the severely subnormal child: a second study

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With the advance of medical science, increasingly precise information is being gained on the part played by heredity in some types of subnormality and a high degree of genetic control is becoming at least technically possible. These medical advances tend to seize upon the imagination and overshadow the less dramatic side of the picture. Yet inheritance is only the beginning of the story: it may set limits to development but cannot determine its course within these limits. Thus if a child has inherited phenylketonuria his environment may well determine whether he becomes mentally retarded or not (in this case, the diet provided).

So we can ill afford to neglect the secondary effects of environment on the mentally handicapped child; for it is only where this is ideal that we can be sure that heredity is setting the pace. For instance, since the publication of Bowlby's monograph in 1951, describing very deprived children in institutions, it has been realized that the classic picture of severely subnormal children may have been a description of what they are like when living in institutions rather than a description of subnormality itself (see Tizard, 1964; Clarke *et al.*, 1958). Certainly most comparative studies of subnormality come out strongly in favour of children living at home (see Lyle, 1959), though Clarke & Clarke (1959) suggest that even the effects of early adverse circumstances may not be completely irreversible.

It is not easy to isolate the elements of deprivation; some think that it is lack of affection which is most damaging and others that it is

insufficient stimulation (see Blank, 1964). Perhaps the two are indivisible; but certainly, as well as the absence of a maternal figure, many institutions provide far less stimulation than a good home (see Rheingold, 1960; Casler, 1965).

However, not all homes are good homes and some may be very unstimulating indeed. A disproportionate number of children from underprivileged homes attend special schools or form the elite of the junior training centres (see Marshall, 1967). But while extreme cultural impoverishment is recognized as a cause of retardation, its secondary effects upon the child who is already genetically impaired has received less consideration. Hence familial studies more often focus on the effect he is having on the family rather than the other way round (see Holt, 1958).

There is much discussion at present on cross-cultural disadvantages; the most obvious example being racial discrimination (see Goldman & Taylor, 1966). Such discrimination arises from the attitude of the community towards the minority group. Similarly, the severely subnormal child belongs to a very small minority group towards which attitudes are often unfavourable and discriminations may be made even between members of the same family.

Not only may the community at large discriminate between the normal and subnormal member in one family; the parents and siblings may also do so. The quality of life experienced by the child may depend to a large extent on his own ability to respond; for the mother-child relationship is interactional, as are all relationships. Perhaps a delay in smiling may itself fail to trigger off the mother's response, or later the talkative child may receive more

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reinforcement than the slow talker. Indeed Spradlin & Rosenberg (1964) found that subnormal children who were verbally inadequate received less stimulation from well-disposed adults than those who were initially more adequate.

A pilot study carried out by the authors (Cashdan & Jeffree, 1966) on 10 severely subnormal children living at home and 10 normal infant school children of the same mean mental age and belonging to a similar socio-economic background upheld the hypothesis that the severely subnormal children, irrespective of the aetiology of their subnormality, would enjoy a less-stimulating environment and less positive affection than a normal child, as shown by parental interviews. Some simple tests carried out on the children themselves were more equivocal.

In the present study a larger group of severely subnormal children from day training centres were matched individually for sex, socio-economic group and mental age with normal children and specially devised tests of 'experiences' were used with the children as well as a revised form of parental interview.

METHOD

Two techniques were used in this study: interviews and tests. While the interviews cover a wide range of rearing practices, both currently and retrospectively, the four tests administered to the children are concerned with 'experiences' they have had. They serve not only to assess whether the experiences have been provided but also whether the child has benefited from them. When further developed the tests may have some value as psychometric instruments in their own right.

Interviews

The interviews were classified into two main areas, affection and stimulation, and each area was again subdivided, making a total of 12 areas as shown in Table 1.

These 12 areas were chosen not only because they were areas in which deprivation seemed

likely to occur, as was largely borne out in the pilot study, but also because they seemed to represent particularly vulnerable points. For instance, Sampson (1968) points out that many stimulating contacts are closed to the handicapped, who may become prisoners of a routine which provides no new experiences and thus, having little occasion to speak, may learn *not* to talk. So not only has language stimulation itself been included, but also many other areas where the possibility exists of building-up communication skills.

Table 1. *Parental interviews*

Stimulation	Affection
1. Language	8. Pride/guilt
2. Adult activities	9. Enjoyment
3. Social contacts	10. Leisure/overwork
4. Outings and occasions	11. Aspirations
5. Everyday life	12. Self-image
6. Play material	
7. Freedom/restriction/ protection	

In considering the mother-child relationship, Holt (1958) found, in a large survey of subnormal children, that many families were overprotective, and Levy (1957) found that grossly over-protected children were inclined to become tyrannical, demanding people, with difficulties in making friends. So both freedom and over-protection and social contacts were included. Similarly, Leeson (1960), in a study of six severely subnormal children and their families, found that all the mothers had been emotionally distressed initially, though some of them eventually adjusted very well, and both Holt and Leeson found some mothers who were overwhelmed with a sense of guilt. As this early mother-child relationship is so important for later development, some assessment of pride versus guilt and of the mother's enjoyment of the baby seemed highly relevant.

The interviews were carried out by the senior author and two trained interviewers with the mothers (and occasionally other relations) in their own homes. They were conducted

in an apparently unstructured manner, in order to avoid the conformity of response with high reliability and low validity often associated with questionnaires. Nevertheless a form of questionnaire was compiled. It consisted of 40 or so questions directed, in effect, to the interviewer rather than to the mother. The interviewer had a copy of this schedule and was required to obtain the necessary information to complete the questionnaire by unobtrusively encouraging the mother to cover all the relevant points. Each area was then rated on a five-point scale (5 being high and 1 low), the criteria for which were specific and well defined. Nearly all the interviews were recorded on tape; this did not often seem to inhibit the mothers, and, as the interviewer did not have to take notes, an uninterrupted flow of conversation could be maintained. It was, however, sometimes found useful to turn the recorder off before the end of the interview, as this helped the mothers to feel free to impart intimate information. The interviewers did not have to rely solely on their memory of the interview and the tapes provided an essential check on their technique and judgement by an arbitrator (A.C.).

Tests

As well as the interviews four tests attempted to assess what meaningful experiences the children had had in the following areas.

Outings and occasions. This test was an attempt to gauge how much the child had benefited from taking part in special outings, treats, etc. The material consisted of 15 plastic bags, each containing five small objects. The child's knowledge of one particular experience was tested by the contents of each bag. For example, for the zoo item, the child's ability to pick out a toy giraffe from a sheep, a ringmaster, a horse and a cat as something he would see at the zoo, would be an indicator of his familiarity with the zoo. His acquaintance with the swimming baths was shown by his ability to pick out a diver from four other distractors. Without this familiarity he was unlikely to choose the correct object from

among the other distractors. His knowledge of the seaside, bonfire night, parties, the circus, etc., was similarly tested.

Everyday life. A test, identical in its nature and administration with the previous one, was designed to assess the child's familiarity with 15 situations typical of everyday life in the community: the hairdresser's, garage, shops, fire station and so on. Thus a bus had to be selected from four other distractors to show the child's experience of travelling about.

Adult activities. Here the child's experience of watching and helping with domestic activities was assessed. Twenty pictures of well-known objects were used. Ten represented father's activities and 10 mother's. The child was shown the first set of 10 and asked if he would like to play a game of mothers and fathers. The first part of the game consisted of helping father and finding what he would need when he was changing the wheel on his car or cleaning his shoes and so on. Similarly the child had to find what mother would need when preparing to make jam tarts or peeling potatoes. Fifteen questions were asked in all and the child had to select the appropriate picture in each case.

Language (nursery rhymes). The child's language experience at home was tested by checking his acquaintance with 15 popular nursery rhymes. He was shown a picture for each rhyme with an essential object missing. Essentially he showed his familiarity with the rhyme by naming the missing object; however, if he showed his familiarity in some other way this was allowed. An object-selection technique was used for non-speaking children, who selected a model spider for 'Little Miss Muffet' for instance, from among several distractors.

The test battery can be administered in about 1½ hours and has been devised for children of mental age 3½–5½. Each part of the battery can be enjoyed as a game which appeals to this age; with older children incidental learning from books and television would make the tests increasingly unreliable. During their construction some checks were made of the tests' validity as tests of experience. For

instance, 20 children were tested from the admission class of an infant school in a working-class area of the city. An experienced class teacher was asked to rank the children for the 'stimulation level' of their homes. Intelligence score, teacher's ranking and test scores all correlated positively with each other. When intelligence was partialled out the other two scores still correlated at 0.62 ($P < 0.05$). Although the tests are not regarded as standardized, care was taken in the selection of items. For tests 1-3 try-outs on groups of normal children from good and poor environments were followed by a high-low item analysis using Fan's tables (1952) and the items finally adopted both met reasonable statistical criteria and showed good face validity. Some 100 or so children were tested altogether on the various try-outs. In constructing test 4, Language (nursery rhymes), a survey of some 80 families established which were the popular nursery rhymes together with the fact that nursery-rhyme telling is relatively unpopular in social class V, though still widespread among the rest of the population. It was not, however, established whether the telling of nursery rhymes discriminated between stimulating and unstimulating mothers. Jeffree (1968) provides further details of the tests and their administration.

Subjects

The subjects were 28 children from four junior training centres in an industrial city and a similar number of four-year-old nursery-class children matched in pairs for socioeconomic group, mental age on the Columbia Mental Maturity Scale and sex. Twelve pairs of boys and 16 pairs of girls were included in the sample (see Table 2).

Table 2. *The subjects*
($n = 28$ in each group)

	Mean CA	S.D.	Mean MA	S.D.
Subnormal	9; 11	14 mth.	5; 1	9 mth.
Normal	4; 5	3 mth.	5; 5	9 mth.

RESULTS

The overall ratings obtained on the interview schedule for normal and severely subnormal subjects were compared and a t test for matched pairs carried out. The ratings for the subnormal children were significantly lower than those for the normal children ($P < 0.05$). See Table 3.

Table 3. *Interview ratings for matched pairs (total scores)*

	Subnormal	Normal
Mean score	36.82	42.79
S.D.	11.45	6.24
t	2.18	$P < 0.05$

For 27 d.f., $t_{0.05} = 2.05$.

The difference between the normal and subnormal subjects on the stimulation areas of the interview fell short of significance. See Table 4.

Table 4. *Interview ratings for matched pairs on stimulation areas*

	Subnormal	Normal
Mean score	21.57	24.43
S.D.	6.67	3.69
t	1.83	n.s.

For 27 d.f., $t_{0.05} = 2.05$.

The difference between the two sets of subjects on the affection areas of the interview was significant at the 5 per cent level. See Table 5.

Table 5. *Interview ratings for matched pairs on affection areas*

	Subnormal	Normal
Mean score	15.25	18.36
S.D.	5.29	3.34
t	2.40	$P < 0.05$

For 27 d.f., $t_{0.05} = 2.05$.

Although some of the ratings for each of the 12 individual areas were not significantly

different for the two groups, they all fell in the expected direction. Further, although the areas of stimulation did not differ significantly when taken together, two of them, 'Social contacts' and 'Freedom/restriction/protection', did differ at the 5 per cent level. The two most significant individual areas of affection were 'Aspiration' and 'Self-image'.

As the interviews were rated throughout on a five-point scale a χ^2 formula was used to compare the frequency of each rating in the two groups. The two groups did not differ greatly at the top end of the scale, almost as many subnormal as normal children being given a rating of 5, but the difference appeared more at the bottom end: no normal mother scored 1 in any area and not many scored 2, whereas these ratings occurred relatively frequently in the subnormal group. See Table 6.

Table 6. *Rating frequency on five-point scale (interview totals)*

	1	2	3	4	5	Total
Subnormal	36	79	91	86	44	336
Normal	0	24	144	122	46	336
Total	36	103	235	208	90	672

$\chi^2 = 83.60$; $P < 0.01$. For 4 d.f., $\chi^2_{0.01} = 13.28$.

Table 7 shows the test scores for the severely subnormal children and their normal controls. The normal subjects were significantly better than the severely subnormal subjects for the battery of tests at the 1 per cent level.

The language test was the only one which did not distinguish between the two groups.

For the normal children the correlations between the interview and test scores for the same areas were fairly high. For Outings and occasions $r = 0.63$, for Everyday life $r = 0.62$, for Adult activities $r = 0.20$ and for Nursery rhymes $r = 0.47$. For the subnormal group the correlations were negligible: $r = 0.03$, 0.07 , 0.17 and 0.01 respectively for the four tests.

A four-way analysis of variance was carried out for the four areas of stimulation as assessed by interview and test for the matched pairs of normal and subnormal children.

Table 7. *Experience tests*

	Subnormal	Normal
Battery of four tests		
Mean	35.36	41.82
S.D.	5.91	7.59
$t =$	4.16	$P < 0.01$
Test 1. Outings and occasions		
Mean	6.79	9.25
S.D.	2.66	3.11
$t =$	3.31	$P < 0.01$
Test 2. Everyday life		
Mean	7.11	9.04
S.D.	5.91	2.12
$t =$	3.73	$P < 0.01$
Test 3. Adult activities		
Mean	9.57	11.93
S.D.	2.35	1.91
$t =$	4.27	$P < 0.01$
Test 4. Language (nursery rhymes)		
Mean	11.93	11.61
S.D.	3.10	3.03
$t =$	0.41	n.s.

For 27 d.f., $t_{0.01} = 2.77$.

There was a highly significant interaction between the two groups and the matched pairs. Apparently normal and severely subnormal children, although matched for mental age, sex and socio-economic group, bear little relationship to one another on measures of experience; the subnormal children being a more heterogeneous group than the normal children. Baumeister (1967) discusses the problem of providing adequate controls for research on subnormal children and suggests that some cross-matching for chronological age may be advisable; i.e. as well as matching the subnormal children with normal controls of the same mental age they should also be matched with a group of the same chronological age, and a further group of subnormal children of the same chronological age as the normal controls should also be studied.

For the normal group some of the tests showed definite correlation with mental age

but this was not so with the subnormal group. See Table 8.

Table 8. *Correlations between MA and the tests*

	Subnormal	Normal
Outings and occasions	-0.14	0.38
Everyday life	0.39	0.51
Adult activities	0.40	0.32
Language (nursery rhymes)	-0.06	0.68

DISCUSSION

This study seems to confirm the suggestion that a child who is subnormal, irrespective of the material level of his home, will have gained less experience in 9 years than a normal child in half that number, although he may have the same mental age. Perhaps it is because it is difficult to take an awkward and unrewarding child shopping or on the bus and bear the remarks or glances of other people, or to talk to him year after year with little response, that many mothers may tire or give it up—perhaps more often than they themselves realize, for they are conscious all the time of the effort they are making.

Again, it is apparent that the severely subnormal child is more in danger of rejection than is the normal child, although many are greatly loved and accepted in the family circle; and this itself may lead to over-protection. It is indeed in these less specific, more long-term aspects of child care that the greatest discrepancies occur in the interviews—in the areas of *social contacts*, *over-protection*, *aspiration* and *self-image*—emphasizing that it is harder to maintain a healthy attitude in these.

Some tentative comments can be made on the techniques used in this study. There appeared to be some halo effect across the interview areas for all groups: mothers tended to appear 'black' or 'white' or average across the whole interview. Yet, for normal children at least, the positive correlations between interview and test results suggest that they have a fair degree of validity. The same cannot be said where the subnormal children are concerned, for the two techniques show little

agreement. The interviewers found the atmosphere more charged with emotion in the home of the mentally handicapped child than in that of the normal child and one would expect the mother's account to be less objective. For the mother of the severely subnormal child the interview is also retrospective and her memory of the early years may not be reliable. Also some of the mothers may have adjusted very well to their retarded child by the time they were interviewed but an earlier visit might have presented a rather different picture.

There is another possibility: the severely subnormal child may sometimes fail to identify objects which are within his experience, either because he lacks the language necessary to inform him on what he sees or because he is a passive partner in these experiences rather than an active participant.

Our studies have now been extended to include a group of physically handicapped children matched for mental age, socio-economic status and sex with the original subjects (to appear shortly).

In the present study, language, which was considered to be one of the most important areas under investigation, provided the least clear results. The language experience tests used with the children were only concerned with the telling of nursery rhymes and, in this respect, there was no difference between the two populations (Table 7). It is now thought that this was a very inadequate gauge of effective language stimulation. Sampson (1968) remarks on having seen backward children reciting like well-trained animals but that the result was not meaningful language. Neither were the results of the interviews much more illuminating in this area, as the normal children did not differ significantly from the subnormals.

However, there are a number of possibilities which need further investigation. A mother of a handicapped child may possibly tend to overestimate the amount she talks to her child, very conscious of the necessity to help him in this way. Another possibility is that it is language divorced from experience that the

children are getting, as certainly they show a deficit in the other experience tests.

Further, the amount of language a child is receiving is probably not so important as the quality of that language and its appropriateness to his situation. Some gauge of this early mother-child communication system is needed, perhaps on the lines of the investigations of mothers which have been carried out by Hess & Shipman (1965).

Work has just been completed on an intervention programme for language enrichment, carried out with mothers of a group of severely subnormal children; the programme being closely linked with the children's other experiences. In this study the mothers are being studied with their children and their communication systems assessed.

SUMMARY

A group of 28 severely subnormal children living at home were matched individually with normal children for MA, sex and socio-economic background. It was predicted that the subnormal children would show a relative deficit on both stimulation and affection measures. On parental interview assessment the groups did differ significantly both overall and in the affection area; the difference in the stimulation area did not reach statistical significance. On four objective tests of experiences there were clear differences overall as well as on three of them taken individually.

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On disillusionment: the desire to remain disappointed*

By CHARLES W. SOCARIDES†

Psychoanalysis, in penetrating the intricacies of ego psychology, has turned increasingly to the study of affects. These involve the whole personality resulting in chronic ego states, thereby inducing the ego to cope not only with underlying conflicts but also with the initiating affect. Affects constitute severe blocks to our therapeutic endeavours and must be treated as strong resistances in order to uncover the infantile material. They loom prominently in the working through process of successful psychoanalytic therapy.

Going beyond Abraham's studies on depression (1911, 1924) and Freud's on anxiety (1926), several affects have received scientific attention, including elation (Lewin, 1950), bitterness (Alexander, 1960), querulance (Schmideberg, 1946), boredom, enthusiasm (Greenson, 1953, 1962), vengeance (Socarides, 1966), sarcasm (Slap, 1966) and smugness (Arlow, 1957).

This paper presents various theoretical and clinical data concerning the affect of disillusionment in order to develop further the psychoanalytic theory of affects. It presents illustrative clinical material and surveys the literature on the subject, welding into a coherent whole the psychoanalytic observations in this important aspect of behaviour. It describes the affect of disillusionment; differentiates between pathological disillusionment and disillusionment as a normal psychic process; and demonstrates the adaptive and non-adaptive use of disillusionment.

Disillusionment varies in intensity from that which is adaptive to catastrophic disillusionment. Genetic considerations are presented as

to origin. As with other affects, the id, ego and superego expressions in disillusionment are in continual interplay; now one, then the other dominating the clinical picture.

Curiously enough, the state of disillusionment often alluded to by patients has received little psychoanalytic attention. But an immensely rich literature challenges us when we explore the contributions of poets, dramatists, novelists and those engaged in philosophical dissertation. It is thrust upon us that man's happiness or unhappiness is intimately related to the illusions he lives by, the reality around him and his condition of disillusionment. Psychoanalysis can only profit from heeding some of these creative utterances on the nature of human vulnerability.

C. Giltman, in his poem 'Disillusionment', emphasizes the self-protective and defensive measures necessary in relationship to others in order to avoid the pain of catastrophic disillusionment:

Let me keep my eyes on yours;
I dare not look away
Fearing again to see your feet
Cloven and of clay.

St Bernard, in *De Consideratione*, bluntly asserts: 'It is a misery to be born, a pain to live, a trouble to die.' Robert Burns, in his poem 'Despondency', exclaims: 'O Life! thou art a galling load, Along a rough, a weary road.' Samuel Johnson in his novel *Rasselas* concluded that 'Human life is everywhere a state in which much is to be endured and little to be enjoyed.' Rousseau observed that 'Man's frantic activity arises from a fear of quiet, the fear that if he is not careful he will glimpse some dimension of reality about himself and then fall into deep despair.'

An unidentified author writes: 'Dying's not the worst. It's living without a dream—or let

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us be less dramatic—without any real reason except that the body still functions—that's what I dread.'

Bellow (1966) cautions contemporary society to divest itself of the vogue to be illusionless:

I am speaking of educated and indeed super-civilized people who believe that a correct position makes one illusionless, that to be illusionless is more important than anything else, and that it is enlightened to expose, to disenchant, to hate and to experience disgust....

Eugene O'Neill 'was haunted by a central theme throughout his life which appeared in most of his plays...Man cannot live without illusions; he must cling to his pipedreams, even knowing they are pipedreams, in order to survive' (Gelb, 1964). In *Don Quixote* Cervantes produced a masterpiece on the subject of illusions and their function.

T. S. Eliot, the poet of disillusion and despair, captured and expressed in verse the sense of a doomed world, of a fragmentation of spirit. He wrote four lines that are possibly among the most quoted of any 20th-century poet:

This is the way the world ends,
This is the way the world ends,
This is the way the world ends,
Not with a bang, but a whimper.

('The Hollow Men', 1925)

Chekhov's play *Ivanov* is a powerful portrayal of the disillusioned man whose condition is complicated by severe depression:

I do nothing and think about nothing...Love is nonsense, caresses are saccharine, work is meaningless, songs and passionate speeches are old and dated. And wherever I go I bring with me misery, a cold boredom, discontent, aversion to live...already tired, disenchanted.

Chekhov's depiction of disillusionment is surpassed only by the description of a disillusioned man in one of Thomas Mann's short stories, 'Disillusionment'. His protagonist asks: 'Do you know, my dear sir, what disillusionment is?...Not a miscarriage in small unimportant matters, but the great

and general disappointment with everything, all that life has in store.' In picturing the early years of his anti-hero as consisting only of words, of shadow rather than substance, form rather than content, an arid environment for affective development, Mann supplies a hint as to the aetiology of the condition.

THEORETICAL CONSIDERATIONS

Six months after the outbreak of World War I, Freud (1915) wrote that the war had brought

disillusionment...It has brought to light an almost incredible phenomenon: civilized nations now understand one another so little that one can turn against the other with hate and loathing...a belligerent state permits every such misdeed, every such act of violence, as would disgrace the individual...We are misled into regarding men as 'better' than they actually are...We are certainly misled by our optimism into grossly exaggerating the number of human beings who have been transformed in a cultural sense...We may derive one consolation...: our modification and our painful disillusionment on account of the uncivilized behaviour of our fellow citizens of the world during this were unjustified. They were based on an illusion to which we had given way. In reality our fellow citizens have not sunk so low as we feared, because they had never risen so high as we believed. The fact that the collective individuals of mankind, the people and states, mutually abrogated their moral restraints naturally prompted these individual citizens to withdraw for a while from the constant pressure of civilization and to grant a temporary satisfaction to the instincts which they had been holding in check...the primitive mind is, in the fullest meaning of the word, imperishable.

Another occurrence which has

shocked us no less than the descent from their ethical heights which has given us so much pain...is the *want of insight* [my italics] shown by the best intellects, their obduracy, their inaccessibility to the most forcible arguments and their uncritical credulity toward the most disputable assertions.

What can ease our disillusionment? Freud's belief is that 'we shall much more easily endure

the disappointment' if our demands were more 'modest... Perhaps they are recapitulating the course of individual development, and... still represent very primitive phases in organization and in the formation of higher unities' (1915).

Regarding death, Freud felt illusions about death should be destroyed.

Should we not confess that in our civilized attitude towards death we are once again living psychologically beyond our means, and should we not rather turn back and recognize the truth? Would it not be better to give death a place in reality and in our thoughts which is its due, and to give a little more prominence towards the unconscious attitude towards death, which we have hitherto carefully suppressed?

Although this seems to be a regression, Freud adds:

I believe it has the advantage of taking the truth more into account, and of making life more tolerable for us once again. To tolerate life remains after all the first duty of all living beings. Illusion becomes valueless if it makes this harder for us (1915).

Strictly speaking, we are not justified in feeling so disappointed if an illusion is destroyed. We 'welcome illusions because they spare us unpleasurable feelings, and enable us to enjoy satisfactions instead' (1915). Therefore we must not complain if sometimes we come into collision with some portions of reality. Our illusions have been helpful up to the moment of our intense disappointment but we must not be 'shattered' by our disillusionment. Freud's concern with these themes is reflected in many of his works during the remaining 15 years of his life (1927, 1930, 1933, 1939).

In 'The Future of an Illusion' (1927) Freud made reference to religious beliefs as illusory. 'And now you must not be surprised if I plead on behalf of retaining the religious doctrinal system as the basis of education and of man's communal life.' He felt that this was a 'practical problem'. One cannot remove this illusion 'precisely on account of its wish-fulfilling and consolatory power'.

In the last section of 'Civilization and Its Discontents' (1930) he wrote:

For a wide variety of reasons, it is very far from my intention to express an opinion upon the value of human civilization... One thing only do I know for certain and that is that man's judgments of value follow directly his wishes for happiness—that, accordingly, they are an attempt to support his illusions with arguments.

Freud's paper on 'Transience' (1916) has direct clinical significance for our understanding of the disillusioned state, although the term 'disillusionment' is not used. It deals with the transient nature of beauty which some people complain interferes with their enjoyment of it.

...to the length of our lives [Freud comments] it can in fact be regarded as eternal... evanescence only lends... a fresh charm... the value of all this beauty and nature of perfection is determined only by its significance for our own emotional lives, it has no need to survive us and is therefore independent of absolute duration.

Freud believed that what spoiled some people's enjoyment of beauty, in actuality their enjoyment of life, was the revolt in their minds against mourning.

Freud asks why this detachment of libido from object should be such a painful process. The mystery is resolved when we consider that the libido clings to its objects and will not renounce those that are lost even when a substitute lies ready to hand. Such then is mourning. But mourning, as we know, should come to a spontaneous end no matter how painful it is,

When it has renounced everything that has been lost, then it has consumed itself and our libido is once more free (insofar as we are still young and active) to replace the lost objects by fresh ones equally or still more precious (1916).

Rycroft (1955) defined the mechanisms involved in the processes of idealization, illusion and disillusion from the point of view of normal and abnormal events in the human psyche. An individual's life may be strongly influenced

by his state of illusion but eventually he may be faced with a

threat of sudden catastrophic disillusion, the collapse of a 'secondary construction' based on illusion and idealization which was maintained as a defence against a sense of despair and futility.

Elaborating upon ideas presented by Winnicott (1945) and Milner (1952), Rycroft states:

...the development of a healthy erotic relationship with reality involves that at the moment of consummation of a wish there should be a convergence and merging of this hallucinated imago (and its cathexis) with the imago of the available external object, not a shift of cathexis from one imago to the other. Failure to fuse these imagos leads to a divorce between the imaginative and intellectual functions, that is, in principle, at least unnecessary. Successful fusion, on the other hand, leads to freedom from the belief that desire and reality are in inevitable opposition to one another.

The hallucinated imago is formed by a double process of introjection and splitting. This mode of formation explains

the compulsion to idealize accompanied by fantasies of internalized bad objects with the subsequent reprojection onto the environment and seeing nature and the environment as actively hostile towards the individual.

One can understand the problem of illusion only if one apprehends that a 'certain primitive adaptation or response to reality has already taken place' in the earliest years of life.

With further reference to the concepts of Winnicott (1945) and Milner (1952), Rycroft describes the process of normal illusion formation and normal disillusionment.

Subjectively, that is, from the infant's point of view, to the extent that external reality has played into its unconscious expectations, it will develop the illusion...that it has created its objects, or to put it the other way round, will be spared for a while the awareness that its objects are not part of its self, have not been created omnipotently by its own desires. Though this illusion will require an eventual disillusion, the disillusionment will be confined to its belief in its omnipotent control of reality, not to reality itself. The healthy

child's hero worship of its parents and its belief in their omnipotence is to be seen as a normal process of idealization which tides it over this period of disillusion until such time as it can rely on its own powers and discovers itself as an individual, potent but not omnipotent.

In pathological illusion formation and pathological disillusionment there has been

a failure of the early environment to maintain a modicum of the satisfaction of impulses, to the extent that they have arisen at all in a frustrating environment...lack firm attachment to the imagos of real, external objects and external reality will be subjectively felt as tantalizing and bad.

Disillusionment is a normal process when it is confined simply to the child's belief in its own omnipotence and not to the value of external reality as a whole. Illusions appear therefore to be an essential part of the mental investment in reality.

Kris (1955) observed that the capacity for appropriate illusion formation seems to constitute one of the earliest stages in neutralization. This predominantly and typically depends on the interaction between mother and child and prepares the way for identification.

Sperling (1951) felt that the inability to form illusions reflected an 'impoverishment of the ego', a symptom which can be observed in many patients. Often when illusions cannot be sustained it leads to general depression and disillusionment and perhaps even to a 'collapse of the whole moral system'. He wonders whether rich and colourful experience in life is possible without illusions and he believes that 'controlled illusions' may be a safe compromise between the reality principle and the pleasure principle.

Jacobson (1964) describes the child as going through

fleeting, though repeated experiences of frustration, which are not yet associated with the love object. Only with the establishment of object relations do they turn into experiences of being hurt and disappointed in the parents as human entities. The total effect of his disheartening experiences is 'disillusionment' ('enttäuschung',

the German term for disappointment)...when disillusionment is experienced before the child is ready to fight his hostile evaluation of the parents with the support of the idealizations, it may arrest the advance of object relations and interfere with normal ego ideal and superego formation, which depend on the child's admiration and respect for his parents.

She feels this may result in the 'cynic', with predominantly selfish infantile ego ideals or in a defective superego formation.

If the boundaries between self and object are still indistinct, according to Jacobson, and libidinal and aggressive forces are able to move freely back and forth between self and object images, disappointment and devaluation of objects will impart themselves

immediately to the self and cause self-devaluation and narcissistic hurt; conversely, narcissistic injuries will induce devaluation of the love objects and disappointment in them.

In the latter case the devaluation of the love objects and disappointment is the disillusionment, the dissatisfaction with the external world.

It would seem that it is the severity of the pre-oedipal disappointments which result in narcissistic injuries which are of vital importance for the formation of pathological disillusionment.

In effect, the belief in good, gratifying external objects is impaired when

early experiences of severe disappointment and abandonment have prevented the building up of unambivalent object relations and stable identification in childhood and weakened the child's self-esteem and his belief in finding love in the future.

CLINICAL CONSIDERATIONS

Disillusionment is a complex emotional state derived from fear and pain in which there is a disappointment in things, as they are not as one had imagined and hoped. This is coupled with a continuing loss of ability to find value and interest in the external world as it actually is. Succinctly, it can be described as the desire to remain disappointed. Three

factors are essential to the definition of disillusionment: (1) The presence of a previously imagined and hoped-for expectation. (2) A loss or disappointment relating to this hope or expectation. (3) A subsequent loss of ability to find value and interest in things as they actually are, i.e. an inability to deal satisfactorily with reality in accordance with the pleasure principle and to make satisfying object cathexes.

The usual responses to experiencing loss and frustration are fear, rage and hate, envy, bitterness, and a host of other emotional states. Depression is an infantile cry in response to loss with the concomitant rage turned against the self and unconsciously designed to regain maternal love, the lost breast, and thereby attain fulfilment.

In demeanour, bearing, gesture and attitude, the disillusioned person dramatizes his basic philosophy: 'So that's what life is all about. This is what one can really expect. I have no further expectations. One can only be deceived, disappointed and hurt. I know all about it.'

Disillusionment must be differentiated from depression. In depression the self is made the target of aggression and feelings of unworthiness while external objects are not denigrated. In disillusionment external objects are bad, while in depression they are not necessarily evil. In disillusionment there is often a self-aggrandizement; in depression the self dwindles with severe loss of self-esteem. In disillusionment the problem is deemed to lie in unsatisfactory external objects, a denial and projection of the intrapsychic conflicts. In depression the self is blamed for both its inadequacies and its failure to gain satisfaction. In the former aggression is externalized; in the latter it is turned against the self. Unlike the depressive, conscious guilt is strikingly absent as a conscious complaint by the disillusioned.

In contrast to the depressed patient, there is often an attempt by the disillusioned to win converts to his feeling of disenchantment with life. Disillusionment may ultimately encase one in hopelessness and despair (quantitative factor). One may go through life without direc-

tion, all values missing, hopes gone, pleasures meaningless. A thread of cynicism may be woven into the fabric of life. Resistant to new experiences, one is also aggrieved against others. Not only does he warn others to avoid expectations in general but he tacitly informs them not to expect anything from him.

The feeling of disappointment experienced in relation to a current frustration should not be confused with disillusionment, the need to *remain* disappointed. A normal reaction of disappointment does not destroy relatedness to external objects or cause one to give up the possibility of gratification. The disillusioned, on the other hand, feel empty and are cut off from libidinal attachments. They are unable to revive their infantile object cathexes which were severely damaged and prematurely destroyed in early childhood instead of having undergone a progressive alteration in significance and meaning for object relatedness and consequent ego fulfilment.

Uncontrolled, unrelieved and pernicious disillusionment proceeds to misery and cold boredom with repressed aggressive libidinal urges; an overriding discontent; an increasing aversion to life; a decrease in the size of the ego, feelings of rage both conscious and unconscious erupting sporadically and alternating with periods of feeling weak; mounting hopelessness giving rise to despair and apathy; a loss of identity, 'I don't know who I am'; a loss of purpose and motivation, 'I don't know what I want'; a loss of overall meaning in life, 'I don't know why I'm living'; ultimately a complete withdrawal of libido.

The numerous overt and covert, conscious and unconscious disappointments in life have varying degrees of significance for the production of pathological disillusionment and its persistence. For example, one may be disillusioned simply because one is mortal. One is disillusioned with the knowledge that under certain circumstances and pushed beyond a certain point men take the law into their own hands and yield to their instinctual aggressive drives or permit others to engage in mass destruction, e.g. on the global level the Nazi

decimation of six million Jews; on the community or individual level the denial of help to a victim of criminal acts (the 'Bad Samaritan').

A persisting common disillusionment befell us upon the assassination of John F. Kennedy, a symbol for many of their own conscious and unconscious hopes, expectations and wishes for achievement (Harris, 1964). The realization that love may be unrequited, that evil cannot be magically eradicated by good, are sources of disillusionment. Feelings of love and hate toward the same person are a source of disillusionment for many. That beauty fades, that things do not last forever, that orgasmic pleasure is brief, may be disillusioning.

The discovery of the differences between the sexes is a deep disappointment and disillusionment to the boy and girl, and a double disappointment to the girl in the oedipal period. Her rejection by the mother and the later rejection by the father are often of crucial importance in her total outlook on the future. The knowledge that parents have their own egoistic interests above and beyond those of their child is an unhappy and rueful day for many children. The knowledge of parental intercourse can give rise to disillusionment. The realization that one is not accepted for 'oneself' but for material or other gain is a source of pain and embitterment.

Middle age, old age and senility bring their special disillusionments, particularly to those who have not consummated their childhood ambitions. Even when childhood wishes have been fulfilled there is often a gnawing feeling on the part of the adult that the price paid in struggle and effort has been far too high and has involved too much sacrifice.

Disillusionment is utilized defensively by those who cannot allow themselves hope because of the inability to bear frustration. It defends against mourning; one remains disillusioned instead of experiencing the more acutely painful affect of depression. Disillusionment maintains a tie to the lost love object; like vengeance (Socarides, 1966), it is a clinging to the old, to the past. There is

a clinging to the memory of previous expectations simultaneously with their dethronement.

The following clinical example, in many ways rich in illustrative analytic content which cannot be commented on due to limitations of space, is presented for two reasons: (1) to enable the reader to share the flavour of the analysis of a disillusioned man, and (2) to depict the affect of disillusionment as a powerful resistance.

PATIENT A

Patient A is a 34-year-old businessman, the only child of Jewish parents, who entered analysis because of premature ejaculation. He suffered from a moderately severe degree of depression, felt socially inferior and complained of an engulfing boredom with life. He also presented numerous hypochondriacal symptoms, mostly related to the gastrointestinal system. For example, he felt he had to completely empty his lower bowel at least five times a day or else would feel uncomfortable. This requirement became intensified whenever he was faced with social situations. He had never been able to ejaculate intravaginally.

He recalled that during early childhood his father would often humiliate him for failing to compete successfully in sports and compared him unfavourably to other children in the neighbourhood. He often teased and derided him with the comment that he was 'just like a girl'. The mother was completely 'browbeaten' by the father and would also turn against her son. The patient has great bitterness towards both parents and although employed as an executive in a major business enterprise owned by the father he works fitfully and listlessly. He felt sure that his father would never promote him to a higher position. It is his bitter, resentful and querulous contention that his father, upon retirement, would even block his 'right' to assume control of the company. He felt entitled to such rewards as within himself he 'knew' that he was the most competent of all his father's employees but he was being 'misjudged and overlooked'.

During the analysis it was evident that he suffered from an unconscious sense of guilt whenever successful. His dreams were filled with dire punishments, feelings of persecution by others and by persecutory internal objects, e.g. faeces,

especially when he asserted himself, attempted to make any satisfactory gains in the competitive areas of life or expressed his enraged indignation. The analysis was marked by his incessant diatribes against the world, against society, against 'ideals' which he proudly and craftily 'saw through' and considered 'a sham, farce and travesty'. Whenever progress was made in therapy and he began to feel more at ease with people he suddenly developed feelings of intense anxiety.

His carping disillusionment with life was a defence against emotional involvement, a projection of his deepest unconscious feelings of internal persecution and a displacement of intense self-destructive feelings on to the external world.

He had married an unattractive, somewhat emaciated and physically immature young woman with whom he felt little sexual, emotional or intellectual affinity. Despite her wishes to have a family the marriage was barren and he was quick to say that he 'would never bring children into this rotten world'. Although he was endowed with some obvious gifts of good appearance, intelligence and unmistakable abilities in the business area, he would never allow himself to profit or experience pleasure through the effective application of these attributes.

He complained that all women were 'out to take you', that all men were 'ready to abuse you', either socially or in business. Friendship is a 'myth' and beneath all virtues lay deceit, falsehood and exploitation. At times his elaboration of this material acquired a paranoid-like quality although he never experienced formal persecutory delusions or semi-delusions.

Boastfully and arrogantly he would let the analyst know that already as a young child he 'knew the score. Life is rotten and no good. Both my mother and father were bastards and the other kids hated me for being a Jew'. Despite his ostensible acceptance of this 'reality', these were all extremely painful memories.

His disillusionment with life and for all things constituted a severe block in therapy. He continuously engaged in a denunciation of the world, its values, including the value of analytic interpretation, ethics, morals, people. This was used by him in the service of resistance both in uncovering infantile material and in acquiring insights and applying them in his life.

'What is life? This is what it is, and I speak without bitterness. It is really basically a very

boring existence. The average life is only giving and being recompensed by a once-a-week card game or by going to the movies once a week. On a special occasion maybe going to a wedding or to a Bar Mitzvah. Life takes from you. You function, work, accept position and worries and the average person gets inconsequential pleasures. I think I'm right and I'm being objective about it. But the average person, you know, doesn't think about it. I take it that isn't what you think, is it, Doctor? Now you—maybe your life is different because you have different opportunities. You see certain people. You get more out of life. No, no, life comes out on the minus side for everyone. It is pretty bland. There is no purpose to it. My wife, she is stupid, too. She enjoys her mother bringing her a simple dishtowel. What are such pleasures?"

His wife, chronically dissatisfied and unhappy in this grim atmosphere, was eventually provoked into leaving him, and within a month after the divorce he decided to terminate the analysis. However, intermittent attacks of severe anxiety forced him to return to the analyst on several occasions.

Significantly it was during these later visits that he reported he was suffering from retarded ejaculation which was interpreted to him as an unwillingness to give anything to anyone, including his sperm—a manifestation of his basic disillusionment with the world. On rare occasions he would grudgingly admit that perhaps his attitudes could be due to his unconscious hate and anger which would break into consciousness at times, that it was because of 'feeling sorry for myself because my mother and father didn't love me or at least that's what I felt. It also may be due to the tendency to hurt myself. It's like cutting off my nose to spite my face. I stop myself from enjoying something special even when I have the chance to'.

He would fill the analytic hour with generalizations, empty dialectics and reduce all activities to a purely mechanistic level. These productions were intended to mitigate an overwhelming fear of discovering his basic conflicts, to give the appearance of communicating and constituted a covert plea and demand that the analyst love him and compensate him for his infantile deprivation. It was also an accusation against the analyst for not providing total fulfilment.

'What do I do today? I get up at five-thirty, get dressed, shave, come here to see you, go to work, work all day, go home, eat, watch television, go

to bed, wake up and repeat the whole thing again. If someone came up to me now and said, "Look, here's a pill. Take it and you'll just disappear as if you never existed and there will be no memory afterwards", I would gladly do it. Do you think I really want to go through today's activities? I used to hope that things were going to be different and that things would be different for me someday but then day after day they are still the same. This life isn't for me. I just can't get into the swing of things...the other people...there's a lot of hate involved. I hate them and it's backed up to my eyeballs. I feel physically tired and don't even want to go to work. If you listen to the average person they bore me. They think they know it all. Most people say a lot of shit...all the shit that comes out of their mouths...They all know it all. They're right...what others say. I always try to look at things objectively, everything is slanted to their way of thinking, though, and it's always prejudiced. They say that they want to believe in others but there are very few people who will speak objectively. It's almost hopeless to speak to people and get the truth out, especially down at the office.

'You're right perhaps when you say that I don't possibly try to get into conversation but it's because people are so biased that they would never say that I was right. I don't think I can expect this. And it's not a matter of patience with them. It's a waste of time. You can't get them to see, the stupid bastards. At a party last night there was some girl talking, something about Europe, and she had only been there once. I have been there twice. It was like she knew it all. I would have deferred if she had been there two times and I only once. But she wouldn't. She was the know-it-all. It doesn't pay to talk to people. Such people only know what they want to know. To 999,000 out of a million life is really pointless. Life is a movie at the end of the week and no person can tell me differently and I'm sure you wouldn't be silly enough to try.

'You get up in the morning and get dressed, you put on your clothes, you go to work, you come home, you eat a meal and you go to sleep. The only thing that might be different is one might have a sex life. But what is sex? Sex is two seconds worth of love. That's all it is. People don't care.' He dwelled interminably on the idea that all of us are equally disillusioned but will not admit it, including the analyst, that everyone knew that life

was meaningless, pointless and without value. The patient wanted the analyst to vindicate him, to grant once and for all that there is no basis for hope and that disillusionment is really the only true and proper attitude towards life.

This case material was unusual in the very fact that he insistently and relentlessly singled out and tried to destroy all hope for himself as well as for the analyst. With such a patient all experiences were interpreted by him in the context of hopelessness. Consciously he claimed his goal was 'to educate the analyst to the facts of life'. This served the purpose of justifying his hostile and destructive attitude towards the analyst and himself and to relieve him of guilt. Unconsciously, however, he greatly feared such affirmation and wished the analyst would prove the opposite through devoting himself to him by 'loving' him and thereby curing him.

Patient A was delighted when he thought he could see any alteration downward in the analyst's mood or any evidence of stress. He would comment: 'Things aren't so hot today, are they, Doctor? Not going so well. Perhaps you'll agree with me now that no effort is worth it and nobody appreciates anything.'

Despite his adamant protests of being without hope or expectation and the tenacity of this position he nevertheless persisted in treatment for two years. Hope must not have been entirely extinguished and disillusionment not complete. It must be pointed out that there was hope in early childhood as revealed in the analytic reconstruction. But there were both traumatic precipitating factors and a gradual

accretion of disappointing experiences from infancy leading to disillusionment in this patient.

SUMMARY

Affects are intrinsically concerned with the psychological development towards genitality. The affect of disillusionment can be a normal phenomenon, a pathological one and, in its extreme form, a shattering one. The solution to pathological disillusionment, the desire to remain disappointed, is renunciation and reinvestment or recathexis of objects as suggested by Freud (1916).

Granted that one of the most painful intrapsychic confrontations any person can face involves the renunciation of established interpersonal dependencies, long term habits and cherished illusions, renunciation constitutes the voluntary divestment of formerly cathected objects, in this instance of a self-damaging nature.

This is a totally different phenomenon from involuntary deprivation. When rejected in love, denied hoped-for recognition, one can produce many rationalizations, claim inevitability or reproach fate. But rationally to scrutinize entrenched but unhealthy relationships, prized but unattainable ambitions, heretofore unquestioned and unsatisfactory techniques and solutions, realizing their non-adaptive nature, achieving their renunciation is a powerful advance in mature integration and acceptance of reality. The choice should be a conscious one, not dependent on external factors. Unless such a choice is made, renunciation achieved, disillusionment avoided, life is faulted and, one after another, all doors to a creative future close, lock and, in time, disappear.

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The motivation and emotional state of 91 cases of attempted suicide

By JOHN BIRTCHNELL AND JOSE ALARCON*

This is the second part of an investigation carried out on 91 cases of attempted suicide seen in the Aberdeen casualty department. The first part (Birtchnell & Alarcon, 1971) was concerned with the measurement of depression in these cases. The present study is concerned with the patients' feelings and intentions at the time of the attempt, and examines the possible differences between men and women in their attitudes towards suicide.

Nowadays the vast majority of those who attempt suicide survive and many would consider that they had probably intended to. As the act is no longer illegal it is perhaps more freely embarked upon and is less scorned upon. Doctors are more prepared to consider it a medical problem. Because drugs are now widely prescribed, and it is known that to exceed the stated dose is relatively safe, the practice of attempting suicide by overdose has spread. All but two of the present series of consecutive referrals are cases of overdose. As the intention of dying is now perhaps less frequent, the motivation for attempting suicide has become more varied and complex. The attempt is more an enactment of dying which carries with it the discharge of some of the emotion appropriate to the actual event. The subject feels he has partly died and those around him experience a limited amount of grief. 'Psychotherapeutic experience and psychoanalytic writings bear ample testimony to the frequency of the equation of sleep and death, and the patient who has taken a moderate overdose of hypnotic drugs often reports uncertainty about which he intended to achieve' (Maddison & Mackey, 1966). This

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acting out of suicide may be sufficient, at least temporarily, to satisfy the subject's self-punitive or self-destructive needs. Unlike the successful suicide, the person who has attempted suicide is in a position to observe the effects of his action upon others. He has the satisfaction of seeing that he has hurt them or of confirming that they would have missed him. The act has cleared the air and, as Stengel (1955), has remarked, 'Often the experience of the suicide attempt signifies death, survival and a new beginning'.

Investigators have demonstrated important differences between attempted and successful suicides, implying that those who merely attempt suicide constitute a somewhat different, though overlapping, clinical group. Though social isolation has been shown to be an important factor in successful suicide (Sainsbury, 1955) studies of attempted suicide (Walton, 1958; Harrington & Cross, 1959; Kessel & Lee, 1962) have shown social isolation to be less important than disturbed social relationships. This may be due to the facts that successful suicide is commoner in older people and that such people are more likely to be socially isolated. Moss & Hamilton (1956) believed a suicide attempt to be 'a miscarried aggressive act directed towards an important figure in the patient's life'. Fellner (1961) considered it as 'the direct outcome of an interpersonal conflict situation with a specific, psychologically important figure'. Whitlock & Schapira (1967) concluded that 'In most of the series in which information is available marital dissension and lovers' quarrels contribute most heavily to the immediate causes of suicidal attempts.' A number of theories to explain the interactions between people which lead to the attempt have been proposed. Zilboorg (1936) suggested

that the subject becomes identified with the once loved and then hated person and 'hurls the whole mass of his hostility on this internalized person; the process of being hostile to the internalized person or persons is perceived as depression, self depreciation and self-hatred, while the act of murder of that person or persons is the act of suicide'. A slight modification of this theory would be that the suicidal act is a means of assuaging the guilt engendered by the murderous feelings towards the other person. Anderson (1949), considering certain cases of chronic grief, described how patients felt they had no right to be alive when someone they cared for was dead, though this too may be because the former relationship was not entirely a loving one. The only way such patients could make amends was to die also. Maddison & Mackey (1966) have dealt at some length with the interpersonal view of suicide and stress that 'relatively little attention has been paid to the psychopathology of the significant other person towards whom the suicidal communication has been directed'.

The aim of the present study is to elicit retrospectively by means of a simple questionnaire: (i) the length of time the subject had thought about the suicidal act, (ii) whether at the time of the act he had wanted to die, (iii) his feelings at the time of the attempt, and (iv) the effect he thought it might have had upon other people. The last item has particular bearing on the interpersonal hypothesis and serves to some extent as a test of it.

METHOD

The sample comprised 91 consecutive cases treated in the Aberdeen casualty department over the 4-month period July–October 1969. Two cases had cut their wrists; the remaining 89 patients had taken overdoses. The majority of patients were detained for at least one night. Only 23 (25.3 per cent) became unconscious; a further 30 (33.0 per cent) were drowsy but rousable. Each patient, in addition to having been assessed by a duty psychiatrist, was seen within 24 hours of recovery by one of the authors and was offered the questionnaire for completion.

The questionnaire consisted of a self-administered depression rating scale (the responses to which have been dealt with in a separate paper—Birtchnell & Alarcon, 1971) and a set of questions relating to the suicide attempt. Each of the latter questions could be answered yes, not sure or no. The patient's feelings at the time of the attempt and the effects he thought it might have on others were assessed by a five- and four-part question respectively. These were chosen by reference to the psychological processes and motivations of suicidal patients proposed in the literature. The phrasing of the questions was intentionally vague so as to allow for a wide variety of life situations and to facilitate classification under a small number of headings. Patients were encouraged to answer 'yes' to as many questions as were thought applicable. No space was left for adding feelings or possible effects not covered by the questions.

RESULTS

Table 1 gives the age and sex distribution of the patient sample. The ratio of men to women of 1:2.4 is similar to that observed in other British studies (Stengel & Cook, 1958; Middleton *et al.*, 1961; Whitlock & Schapira, 1967). The relatively high proportion of teenage girls has also been reported elsewhere.

The period of contemplation of the suicide attempt

Patients were asked if they had thought about the attempt for months, weeks, days, minutes or not at all. There were 39 (42.9 per cent) who had thought about it for minutes or not at all, 23 (25.3 per cent) who had done so for days or hours and 29 (31.9 per cent) who had done so for months or weeks. The studies of Harrington & Cross (1959), reporting that 61.8 per cent of attempts were unpremeditated, and James *et al.* (1963), reporting that 66 per cent were impulsive, tend to support the idea that suicide attempts, perhaps in contrast to successful suicides, are poorly planned, spontaneous reactions to stressful circumstances. It might be anticipated that young people would be more likely to make an impulsive attempt. In fact,

Table 1. *Age and sex distribution of the patient sample*

	Men	Women	Total
< 20	1	22	23 (25.3 %)
20-29	6	12	18 (19.8 %)
30-39	9	13	22 (24.2 %)
40-49	3	9	12 (13.2 %)
50-59	4	4	8 (8.8 %)
> 59	4	4	8 (8.8 %)
Total	27	64	91

Table 2. *The period of contemplation by sex*

Period of contemplation	Men	Women	Total
Minutes or not at all	5 (18.5 %)	34 (53.1 %)	39 (42.9 %)
Days or hours	9 (33.3 %)	14 (21.8 %)	23 (25.3 %)
Months or weeks	13 (48.1 %)	16 (25.0 %)	29 (31.9 %)
Total	27	64	91

$2 \times 3 \chi^2$ comparison: $\chi^2 = 9.4856$; d.f. = 1; $P < 0.01$.

the figures for the under-20 and over-39 age-groups are similar, 52.2 and 50.0 per cent respectively; the intermediate group being somewhat lower, 32.5 per cent. Table 2 shows that, irrespective of age, the men and women differed significantly in their periods of contemplation; in particular 53.1 per cent of the women, compared with only 18.5 per cent of the men, acted impulsively. This significant sex difference has not been previously reported.

The wish to die at the time of the attempt

Patients were asked whether at the time they had actually wanted to die. Forty-two (46.2 per cent) said they had, 15 (16.5 per cent) were not sure, and 34 (37.4 per cent) said they had not. Slightly more of those aged under 30 (53.7 per cent) than those aged 30 or more (40.0 per cent) said they had wanted to die and slightly more men (55.6 per cent) than women (42.2 per cent) said so. These differences are not significant. Harrington & Cross (1959) reported that 50 per cent had intended to kill themselves. As might be expected, there is a significant relationship between the period of contemplation of the

act and the wish to die. Of those who had thought about it for months or weeks 62.1 per cent had wanted to die, whereas of those who had thought for minutes or not at all only 28.2 per cent had wanted to die. Furthermore, 20 of the 22 patients who had acted impulsively and who had not wanted to die (90.9 per cent) were women.

The feeling of the patient at the time of the attempt

Five possible feelings were suggested in the questionnaire, two relating to the past ('sorry or ashamed of something' and 'feeling you had failed in life'), two relating to the present ('angry with someone' and 'feeling lonely or unwanted') and one relating to the future ('worried about the future'). The mean number of 'yes' responses to the five questions was 1.96; 2.37 for men and 1.78 for women. Only seven patients (7.7 per cent) failed to make at least one 'yes' response. It would appear that the more serious the suicide attempt the more positive responses were given. Those for whom the attempt had been partly manipulative may have been less inclined to answer. Those who had contem-

Table 3. *The wish to die by the number of 'yes' responses: patient's feeling at the time of the attempt*

Number of 'yes' responses	Wanted to die (<i>n</i> = 42)	Unsure (<i>n</i> = 15)	Did not want to die (<i>n</i> = 34)	Total (<i>n</i> = 91)
0	0 (0.0%)	0 (0.0%)	7 (20.6%)	7 (7.7%)
1	12 (28.6%)	5 (33.3%)	14 (41.2%)	31 (34.1%)
2	10 (23.8%)	6 (40.0%)	8 (23.5%)	24 (26.4%)
3 or more	20 (47.6%)	4 (26.7%)	5 (14.7%)	29 (31.9%)
Total number of 'yes' responses	98	32	48	178
Mean number of 'yes' responses	2.33	2.13	1.41	1.96

$2 \times 4 \chi^2$ comparison, wanted to die/did not want to die: $\chi^2 = 15.7080$; d.f. = 3; $P < 0.01$.

Table 4. *Patient's feeling at the time of the attempt: 'yes' responses only*

Feeling	Men		Women		Total	
	% of number of responses	% of total (<i>n</i> = 27)	% of number of responses	% of total (<i>n</i> = 64)	% of number of responses	% of total (<i>n</i> = 91)
Sorry or ashamed of something	12 (18.8%)	44.4%*	12 (10.5%)	18.8%*	24 (13.5%)	26.4%
Feeling you had failed in life	16 (25.0%)	59.3%**	22 (19.3%)	34.4%**	38 (21.3%)	41.8%
Angry with someone	10 (15.6%)	37.0%	22 (19.3%)	34.4%	32 (18.0%)	35.2%
Feeling lonely or unwanted	13 (20.3%)	48.1%	35 (30.7%)	54.7%	48 (27.0%)	52.7%
Worried about the future	13 (20.3%)	48.1%	23 (20.2%)	35.9%	36 (20.2%)	39.6%
Total number of 'yes' responses	64	—	114	—	178	—

* $\chi^2 = 6.4562$, d.f. = 1, $P < 0.02$.

** $\chi^2 = 4.8348$, d.f. = 1, $P < 0.05$.

plated suicide longest gave the most positive responses. Table 3 demonstrates that those who had wanted to die gave significantly more positive responses than those who had not. Table 4 presents the positive responses to each of the five feelings listed. Interpretation of the table is complicated by the fact that men tended to give more positive responses than women. The men exceeded the women most for the two feelings relating to the past. The women appeared more concerned with present feelings. Feeling lonely or unwanted is the only instance of the women obtaining a

higher response than the men. The two sexes seemed to be equally worried about the future.

The effects the attempt might have upon other people

Four possible effects were suggested: two submissive or accommodating ('show how much you loved someone' and 'make things easier for others') and two retaliatory ('make people feel sorry for the way they have treated you' and 'frighten or get your own back on someone'). The mean number of 'yes' responses was 0.91; 1.11 for men and 0.83 for

Table 5. *The wish to die by the number of 'yes' responses: possible effects upon other people*

Number of 'yes' responses	Wanted to die (n = 42)	Unsure (n = 15)	Did not want to die (n = 34)	Total (n = 91)
0	8 (19.0 %)	5 (33.3 %)	17 (50.0 %)	30 (33.0 %)
1	23 (54.8 %)	7 (46.7 %)	14 (41.2 %)	44 (48.4 %)
2 or more	11 (26.2 %)	3 (20.0 %)	3 (8.8 %)	17 (18.7 %)
Total number of 'yes' responses	50	13	20	83
Mean number of 'yes' responses	1.19	0.87	0.59	0.91

$2 \times 3 \chi^2$ comparison, wanted to die/did not want to die: $\chi^2 = 9.2611$; d.f. = 2; $P < 0.01$.

Table 6. *Possible effects upon other people: 'yes' responses only*

(The differences between men and women, for separate items, are not statistically significant.)

Effect	Men		Women		Total	
	% of number of responses	% of total (n = 27)	% of number of responses	% of total (n = 64)	% of number of responses	% of total (n = 91)
Show how much you loved someone	11 (36.7 %)	40.7 %	21 (39.6 %)	32.8 %	32 (38.6 %)	35.2 %
Make people feel sorry for the way they have treated you	2 (6.7 %)	7.4 %	9 (17.0 %)	14.1 %	11 (13.3 %)	12.1 %
Frighten or get your own back on someone	4 (13.3 %)	14.8 %	5 (9.4 %)	7.8 %	9 (10.8 %)	9.9 %
Make things easier for others	13 (43.3 %)	48.1 %	18 (34.0 %)	28.1 %	31 (37.3 %)	34.1 %
Total number of 'yes' responses	30	—	53	—	83	—

women. A relatively high proportion (33.0 per cent) failed to make even one 'yes' response. Again, the more disturbed the patients were the more positive responses were given. For instance, 46.2 per cent of those who had contemplated the act for minutes or not at all gave no positive responses. Table 5 shows a significant relationship between the wish to die and the number of positive responses given. Table 6 presents the positive responses to each of the four effects listed. As before, the men in general gave more responses. A smaller proportion of both sexes admitted to a retaliatory motive. For women the most frequent effect was to

show how much they loved someone. For men it was to make things easier for others. The latter is probably a potentially more dangerous attitude as it is suggestive of a feeling of worthlessness. No relationship was apparent between the period of contemplation or the wish to die and either the feelings or proposed effects.

DISCUSSION

It is difficult to ascertain the subjective feelings of cases of attempted suicide because of the attitude of both patient and doctor towards the attempt. Patients do not like to admit even to themselves that they have

done such a thing. Twelve (13.2 per cent) maintained they did not remember what they had done to cause them to be in the casualty department. In the study of Harrington & Cross (1959) 37 cases (36.3 per cent) claimed amnesia for the actual event. They may fear that they will be disapproved of and further that they may be considered insane and recommended for treatment. For such reasons they may deny that they wanted to die and that they had thought about it for very long. It is possible therefore that the number who said they intended to die is an underestimate and that patients had in fact contemplated suicide longer than is recorded. Certain feelings (e.g. angry with someone) and intentions (e.g. frighten or get your own back on someone) may be denied or repressed and may be elicited only during a psychotherapeutic interview. At a more superficial level they may merely be considered less acceptable.

It may be argued that during the period immediately following the suicidal attempt the subject's emotional state may be markedly different from what it was beforehand. His recall of his feelings at the time or of his intentions may be affected by his altered mood. He may feel relieved, less bitter, remorseful or even gratified by the already perceived response of those who rescued him or who have visited him.

Each method of collecting information about patients' emotions has its disadvantages. It may be argued that it is easier for subjects to tick off appropriate statements than to agree to or deny them when put by an interviewer. When left to volunteer their own feelings patients may be tempted to choose a vague remark such as that they were tired of life and are not compelled to consider a variety of possibilities. In a situation other than a carefully structured interview they may be biased due to the permissiveness or expectations of the interviewer. The therapist's interpretation that the patient was angry may be related to a predetermined theoretical model. Further, unless it is made clear exactly what question was put to the patient it is

difficult to assess the recorded reply. The statement by James *et al.* (1963) that 'sixty-six of the patients studied said that their attempt had been impulsive and unpremeditated until shortly before' depends upon what is meant by 'shortly before'.

Bearing these points in mind is it safe then to accept that perhaps 50 per cent of all suicide attempts are unplanned, spontaneous acts and that only a similar proportion had actually wanted to die or intended to kill themselves? Kreitman *et al.* (1969) have recently asserted: 'The only point on which everyone seems to be agreed is that the existing term "attempted suicide" is highly unsatisfactory, for the excellent reason that the great majority of patients so designated are not in fact attempting suicide.' Stengel (1970), in response to this assertion, maintained that individuals committing acts of self-damage are often incompletely aware of the motivations and purposes of those acts. He believed that at the same time they want both to die and to live, 'usually the one more or much more, than the other'. James *et al.* contended that a denial of suicidal intent should be accepted with great caution and described a woman who made such a denial and subsequently committed suicide. Further, certain patients determined to kill themselves will deny suicidal intent vehemently in order that they may be given the chance to try again at an opportune moment. Shneidman (1967) stated that 'Some people who commit suicide do so the first time they attempt it, but the more common pattern is that of a series of attempts, with increasing lethality.' A reasonable compromise may be to consider that most people attempting suicide are at least experiencing the fantasy of dying but that for some the fantasy proves inadequate and subsequently they opt for the real thing. Taking an overdose of sleeping tablets is producing a longer and a deeper sleep than normal which approaches more closely the interminable sleep of death.

There is an important sex difference in attitude towards suicide. Though most studies

of attempted suicide report an excess of women, the reverse is the case in studies of successful suicide. In the present study fewer women expressed the wish to die and significantly more attempted suicide impulsively. In the previous study (Birtchnell & Alarcon, 1971) the mean depression score was higher for men, 33.27 compared with 30.36 for women. The general inference is therefore that men are more reluctant to attempt suicide; they think about it longer; they need to be more depressed; and when they do it they are more determined and consequently more often they succeed. It is reasonable therefore to expect, as is suggested by the present findings, that men would dwell more upon past failures and women would respond more to present frustrations. It would be unwise to conclude, however, that unpremeditated suicide attempts by women are always less important than the more carefully thought out attempts made by men. Whitlock & Schapira (1967), considering a group of 33 girls labelled 'adolescent crises', concluded: 'Undoubtedly many of these patients were briefly but seriously disturbed, and in some cases the suicidal attempt was a most dangerous one.'

The relatively high response to the suggested feelings at the time of the attempt—only 7.7 per cent declining to agree to at least one of them—is confirmation that they are representative of the emotional state of people who attempt suicide. There may, of course, be others which were not included. That 59.3 per cent of the men felt that they had failed in life is perhaps indicative of the need for men to succeed in their work and attain the goals they have strived for. On the other hand, the state most admitted to by the women (54.7 per cent) was that of feeling lonely and unwanted. This perhaps reflects the need for women to be chosen, preferred and valued by men, upon whom they are obliged to depend by virtue of their domestic and maternal responsibilities.

The response to the suggested effects of the attempt was poorer, 33.0 per cent declining to admit to at least one. This may be due to a

reluctance to confess to any underlying motive. Alternatively, it may argue against an interpersonal interpretation of suicidal behaviour. Because of the relatively low response, interpretation of answers is less reliable.

The variety of diagnostic groupings adopted by investigators of attempted suicide is a reflexion of the difficulty which is frequently encountered in fitting such patients into the conventional, psychiatric, diagnostic categories. Kessel (1965), for instance, was of the opinion that 21 per cent of his sample were not psychiatrically ill at all. It is clearly important to detect cases of treatable illness; yet it should be borne in mind that only a proportion of even severely depressed patients have suicidal tendencies. In understanding the aetiology of suicidal behaviour it is therefore advantageous to concentrate also upon areas of psychopathology. However, such reports along these lines as have been published, e.g. Tabachnick (1961) and Hendin (1963), are largely anecdotal. There is a need for more systematic investigations and the present one is clearly only a beginning.

SUMMARY

1. A consecutive series of 91 cases of attempted suicide seen in the casualty department of a Scottish university city was investigated. There was a high proportion of teenage girls and women outnumbered men by a ratio of 2.4:1. All cases were given a short questionnaire to complete.

2. Men and women differed to a significant extent in the period of contemplation of the suicidal act. Over half the women had thought about it for only minutes or not at all.

3. Only 46.2 per cent of the patients admitted to wanting to die at the time of the attempt. There was no relationship between the wish to die and either age or sex. However, there was a significant association between the period of contemplation and the wish to die.

4. Five possible feelings at the time of the attempt were suggested. Only seven patients failed to admit to at least one of these and the mean number of positive responses was 1.96. Those who had wanted to die admitted to significantly more feelings. Men appeared to be

relatively more concerned with the past and women with the present.

5. Four possible effects of the attempt were suggested. A higher proportion (33.0 per cent) failed to agree to at least one of these. The mean number of positive responses was consequently lower (0.91). Again there was a significant relationship between the wish to die and the number of such responses. Relatively fewer patients admitted to the less acceptable motives of retaliation.

6. The significance of the suicide attempt and

the difficulty of ascertaining to what extent this represents a wish to die is discussed.

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Cognitive dysfunction in childhood and adult psychosis

By J. G. LYLE*

Whether psychotic children who apparently grow out of their psychosis are later particularly susceptible to adult forms of psychosis is not known. Such a connexion cannot be assumed, but a tenuous link does exist. McGhie & Chapman (1961, 1965), Chapman & McGhie (1962) and Lawson *et al.* (1964) have hypothesized a causal connexion between difficulties in decoding incoming sensory information and some forms of thought disorder. According to these investigators, thought disorder is consequent upon an inability to process sensory data, especially heard speech, selectively, or rapidly enough (Yates, 1966) so that only confused or inchoate information is relayed to the higher integrative centres. This confusion is then manifested as a disturbance of higher thought processes.

Psychotic children frequently have histories of anomalous speech development. Indeed Rimland (1965) has suggested that defects in the decoding of linguistic and other sensory data, or in the selectivity of associative processes, are inherent aspects of certain types of childhood psychosis. Now, according to the previously described hypothesis concerning data-processing and thought disorder in adult forms of psychosis, children who suffer decoding difficulties might be expected to be particularly prone to develop 'thought disorder' later in life.

An unusually instructive case is presented of an intelligent adolescent boy with a well-documented history of cognitive and behavioural pathology. Mute in infancy and diagnosed as psychotic, he made a surprisingly good recovery in later childhood in respect of general behaviour and verbal communication.

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In adolescence he lapsed into a schizophrenic-like breakdown characterized by marked confabulatory tendencies. The case has implications for hypotheses which link linguistic dysfunctions with thought disorder. It also has implications for the understanding of some aspects of psychotic behaviour in childhood as reactions or adaptations to cognitive dysfunctions.

THE CASE OF DAVID

Referral

At 17 years 4 months David was referred for neurological assessment following three *grand mal* seizures. There was no previous history of seizure. He was subsequently referred to the psychologist for educational guidance.

He had failed the third year of secondary school after having repeated two previous grades, and was now too old to continue at school. The following history of development was elicited from David himself, from his parents, and from documented sources.

Birth

Pregnancy and birth apparently normal, but there was evidence of severe anoxia at birth, the baby being blue-black in colour. No transfusion was carried out. Suckling reflex was inadequate, and he was artificially fed for a week. Birth weight: 7 lb. 12 oz.

Genetic

No evidence of pathology in grandparents, parents of sibling, but mother's brother died in *status epilepticus* at 18 years, cause unknown. (This was at about David's present age.) Father Jewish, a solicitor.

Developmental

Locomotion. 0-5 years: sat up at 6 months; walked at 15 months. 5-9 years: marked clumsiness made him unable to join in games with

others. Played alone, especially at constructional games, at which he was inventive. 9–17 years: clumsiness precluded all organized sport except swimming, which he did well. When seen by the psychologist he was a large awkward lad, but without manifest incoordination; right-handed.

Speech. 0–5 years: a few single words at 9 months, but stopped talking at 12 months. From this time onwards he would only make strange noises or speak in jargon, which was often put to tunes. Comprehension of speech was either completely absent or very limited. Began to speak again at 4 years in truncated sentences, but would often stop in mid-phrase. 5–9 years: speech retarded until 7 years, then improved rapidly; articulation clear. 9–12 years: complained that word meanings often eluded him at school, and comments to this effect appeared in his school reports. 12–17 years: noticeably slow and deliberate in speech when seen by a psychologist, but adequate fluency. Comprehension adequate for ordinary conversation, but lost the gist of complex questions or instructions.

Scholastic. 5–9 years: began primary school at 5½ years. Reading and writing were difficult to learn from outset. Until the third year of primary school he learned very little; but from the fourth year onward he learned to read and write without remedial help, though he was very slow at these tasks. 9–12 years: improved markedly in Grade 5 under tutelage of interested teacher. 12–17 years: fell rapidly behind in secondary school because of difficulty in 'understanding anything at first serving'. His final school report attested that he needed time to understand what was written or spoken, and also to express himself in writing. At mathematics he was particularly slow, though he could solve problems, given time. He had failed in English, French and mathematics.

General. 0–1 year: from 9 months, peculiar behaviour was noted in the form of head and eye movements by which he followed the visual patterns on curtains, lines of brickwork, etc. 1–5 years: strange eye movements continued, to which were added incomprehensible gesticulations and rocking. The latter behaviour was carried out rhythmically to tunes when he was in bed. He seemed to need constant physical contact with his mother, and for long periods would sit on her knee and explore her facial contours with his own face. 5–9 years: in early school grades his behaviour was unmanageable. He had no 'social

consciousness'; he would sing to himself in class and behave in other inappropriate ways. When 'picked on' by other children, he would retaliate furiously. At 6 years he was taken to a psychiatrist, who revealed the presence of hallucinations, and pronounced him psychotic. His behaviour improved steadily between 7 and 9 years. 9–12 years: very much improved at home and in class, though still considered an odd lad. He gained a measure of acceptance among his peers, but had no personal friends at all. 12–17 years: much improved at home and at school. No behaviour problem except lack of friends.

Psychological assessment at 17 years

WAIS. Verbal IQ 129; Performance IQ 100; Full Scale IQ 118. *Wechsler Memory Scale:* MQ 115. *ACER Oral Reading:* 129 words per min., fluent and without error. *ACER Silent Reading:* 67 words per min.; when administered as an oral reading test he read fluently at 125 words per min.

The discrepancy between the two reading tests was most significant, his poor silent reading being due to his having to re-read each paragraph to comprehend the meaning, which must be indicated by underlining relevant words contained in multiple-choice items. (His Memory Quotient indicates that it was not merely a memory deficit.) *Rorschach:* 35 responses characterized by good form level, high percentage of Movement responses, and low F%, suggesting imaginative lability.

INTERVIEW WITH DAVID

Early hallucinations. David remembered his early hallucinations clearly, and details had been recorded on clinic files 11 years previously. They took the following forms.

Black cone-shaped objects would appear over the edge of his bed. If he put his head under the bedclothes they would still be there. Holes would appear in solid objects, and the black shapes would sometimes emerge from these. Black objects would seem to float in the air, and holes form in these. Rectangles and cones would seem to chase each other around the floor, making a scuffling noise. Coloured lights would appear in the air or on walls. These hallucinations were often accompanied

by ominous droning noises, and intense feelings of fear accompanied all these phenomena.

The hallucinations began before the age of 3 years and began to decrease in frequency at about the age of 5 years. No hallucinations reported since the age of about 9 years.

Speech. He remembered trying to communicate with his parents by means of adopting particular snatches of tune to represent a need. His mother was able to recognize some of these attempts. Also he would try to communicate sounds which to him were evocative of certain situations, e.g. the sounds of a car crossing a bridge by way of requesting a car ride.

General. In bed, he found that by rocking rhythmically the hallucinations would go away. He sang rhythmically while rocking to quell his fears. Although he often reacted fearfully to the hallucinations, he could not tell anyone about them in the early years, and later he did not tell because he realized that these were experiences not shared by others. He would become very fearful if he saw tents, or distant mountains, or boxes which resembled the hallucinatory shapes.

Diagnosis. From the foregoing data and from a neurological report the following conclusions were drawn: (1) David had manifested temporal lobe phenomena in early childhood, possibly arising from severe anoxia at birth, though there also may have been a genetic basis. (2) His earlier dysphasic condition had improved until it was no longer a problem. However, his present dyslexic condition seemed to be a continuation of the dysphasia in the sense that it involved incomprehension of word meanings. (3) His present adjustment was remarkably good in view of his anomalous development.

Special permission was obtained from the Education Department for David to do his final examination with extended time limits on account of his epilepsy. A correspondence course and a private tutor were arranged for him. He passed this examination at the end of the year.

SUBSEQUENT PSYCHOTIC BREAKDOWN

Fifteen months after the original referral David was admitted to mental hospital with 'florid undifferentiated schizophrenic symptom's, inappropriate verbal behaviour and flight of ideas. He was tested in hospital 3 weeks after admission, when these symptoms had abated.

Bellevue Wechsler: Verbal IQ 105; Performance IQ 96; Full Scale IQ 99. Qualitatively, difficulty in selecting appropriate definitions were noted, e.g. *bad*: 'A defiance of anything; any deed which is unwelcomely foreign; in general, with respect to society to a large degree'. *Rorschach*: Production very high ($R = 110$) with a large number of wildly confabulatory responses; that is, the cards set off fantasies which were only loosely connected with the stimuli; e.g. *Card IV*: 'The scene from *Symphonie Fantastique* by Berlioz; the funeral scene. That reflects the strange floor. Fantasy scenes...witches have made the floor very deep, like a crystal ball. There he is being carried. Those are all the sylphs dancing on top...no, that's the Damnation of Faust. Here's the unquenchable fire that keeps burning up. Fates and the ordinary world outside; reflexions of hills, lake. World with no top or bottom'.

Thought disorder. David was interviewed by the psychologist, and his responses were copied verbatim by a secretary. Speech was fairly rapid, but coherent. He stated that he had been in a high state of tension at time of referral; he felt 'as if a full scale civil war were being launched, with myself at the centre'.

The civil war took place in a country called Sobraltan. He drew a map, which was a schematic drawing of the human brain. It was divided into provinces, some of which he had named. Most of these provinces had fabricated names, but the most important one was in the 'prefrontal' part of the map, and termed the Sex Region. There was also an Emotional Region, a Pleasure Region and a Laughing Region. He had progressively

invented a history of the warfare which had taken place in the country, together with names of political and military leaders. 'After much fighting, the revolutionaries had completely taken over, and I was placed under severe restrictions.' (Who were they fighting? — 'The Devil'.) There appears to have been no auditory hallucinations; his orders were received 'through the mind'. The restrictions placed on him were to attend Holy Communion every week, and he was rationed on friends. Girl-friends were ruled out completely, 'because after a few hours they could bring down the government'.

But then he received an 'ultimatum'. He was confronted one morning by the devil, who said, 'Who are you going to fight—the Devil or God?'. David said, 'God', and the devil replied, 'All right, I'll roast things ready for you'. (It could not be elicited reliably whether this was a hallucination, or whether it was just fantasy.)

Eventually, the official head of state resigned and General Krushenbarm formed a democratic government. This government adopted an anti-feminist policy. Feminists were outlawed, but they formed the 'Crack Front'. The government took control of the country slowly: the Sex Region was the last province to fall. The Crack Front then formed a subversive organization: 'The Organization of the Sacred Rehabilitation of the Correct Sex'. 'According to them, I was female, and they would seek sex conversion if they gained control.'

The Crack Front was routed just about the time of his admittance to mental hospital because of their failure to recruit popular feminine support—only homosexuals would support them. The revolution ended when they blew themselves up in a building called 'The Poison Image': Parliament House and the Presidential Palace were also blown up. The government took control and a State of Personality was declared.

Queried about the time scale of this fantasy, David said that it had been going on for about a year. However, ever since he was a lad of

about 10 years he was given to solitary fantasy, inventing humorous or exciting situations for himself, and drawing maps of fabulous countries.

Follow up

A follow up after 5 years revealed that David had been readmitted to mental hospital for a disorder described as 'schizophrenia, withdrawn type with hallucinations; and chronic undifferentiated convulsive disorder'. Intelligence testing indicated no further dementia. Since that time, he has made a good social adjustment in a sheltered workshop, where he has been described as happy, sociable, but very clumsy in his work. He lives in rented quarters; he has joined a church group, where he dances; and he has strong interests in classical music.

DISCUSSION

It is apparent that several aspects of David's early psychotic behaviour could be explained in terms of disturbance of consciousness, communication difficulties, discrepant abilities, and his reactions and adaptations to these. Some of his behaviour was reactive to his temporal lobe hallucinations, e.g. irrational fears; and some behaviour was adaptive to them, e.g. rhythmic rocking to make them disappear. Some of his behaviour was adaptive to his aphasia, e.g. humming tunes and making associative noises to communicate with his parents. It is likely, too, that in infancy he suffered difficulty in interpreting visual data, hence his curious following of patterns with gross head movements and his exploration of mother's face with his own.

David's behaviour improved progressively in his middle years as the hallucinations ceased and as speech developed. His schizophrenic breakdown in adolescence was quite out of context with this history of behavioural improvement. It is difficult to find any direct connexion between David's childhood psy-

chosis and his later breakdown. The latter was manifested as a thought disorder, while the former consisted of meaningless visual and auditory disturbances and unsocialized behaviour.

The question is whether David's long-standing difficulties in the decoding of language played a causal part in the schizophrenic thought disorder. His early condition seems to have been similar in effect, if not in kind, to that postulated by Yates (1966) as leading to thought disorder. According to Yates, slowness in processing information leads to loss from an overloaded short-term memory system. Only fragmentary information could thus be relayed to the higher cognitive levels, giving rise to an apparent confusion of thought. In a personal communication, Yates indicated that he would expect to find these effects mainly in cases of non-paranoid thought disorder of endogenous origin, in which there was evidence of long-standing decoding problems. David's case seems to have fitted these criteria very well.

During his adolescent breakdown David's excited and inappropriate verbalizations, common at the onset of certain psychotic disorders, would also seem to fit hypotheses of a thought disorder based upon fragmentation of information or upon uncontrolled associations. Yet examination of the content of the thought disorder indicated that this was certainly not based upon confusion of meaning. On the contrary, it consisted of fantasy which was quite coherent within itself. Similarly, the many confabulatory responses on the Rorschach owed their strangeness not to any confusion, but to the fact that they were produced from an almost entirely autistic frame of reference. Neither did his schizophrenic fantasies seem like uncontrolled associations, since they centred fairly obviously upon his own sexual problems. His Rorschach productions were not uncontrolled, though they were minimally related to the stimuli; they reflected his interests in music and literature. For these

reasons it is difficult to see how his earlier difficulties in decoding language could stand in any causal relationship to his later thought disorder.

Study of the development of his fantasies indicated that they began in early childhood as his verbal ability improved. They began as an innocuous preoccupation with a world of his own imagining, which he progressively embellished, and into which he assimilated his own problems. Eventually the whole imaginative schema took on the urgency of reality. The excited 'inappropriate' verbalizations with homosexual references at the onset of his psychosis were in fact reactive to his own frightening fantasies.

Improved verbal ability would have been necessary for the development of the highly verbal fantasies which formed his adolescent psychosis. It was thus unlikely that his linguistic difficulties resulted in his schizophrenia; rather it was linguistic development which made possible the construction of his fantasy world. His earlier linguistic difficulties, however, did enhance the social isolation which gave rise to his retreat into fantasy. Possibly, too, his infantile hallucinatory experiences may have made him more ready to accept unreality as a fact of life.

The case of David may be added to the list of schizophrenic-like psychoses of epilepsy described by Slater & Beard (1963 *a, b*). Like many of the cases reviewed by Beard (1963), there was evidence of temporal lobe involvement, though none of their cases began with autism-like behaviour in infancy. (The relationship between infantile autism and subsequent epilepsy warrants further study.) These authors considered the possibilities (a) of chance coexistence of schizophrenia and epilepsy, (b) psychosis as a reaction to epilepsy, and (c) of both arising from the same causes. David's breakdown in adolescence may have been precipitated by the anxiety engendered by the seizures, or it may have been related to deteriorating neural events, of which the seizures were also a symptom.

However, in this case it seems likely that the thought disorder was, at least in part, due to the social effects of the early undiagnosed temporal lobe symptoms and related behavioural disorders. His late development of language seems to have produced the means of his psychotic thought disorder in adolescence rather than having caused it by default. The genetic component of the convulsive disorder should also not be forgotten.

SUMMARY

The case is described of a boy diagnosed as autistic and dysphasic in childhood. Although he staged a good recovery, he suffered a psychotic breakdown in adolescence. Hypotheses that long-standing difficulties in the processing of speech may lead to thought disorder are considered within this context. Aspects of his psychotic behaviour in childhood and of his later schizophrenic-like behaviour are considered as reactions and adaptations to his earlier cognitive dysfunctions and to his consequent social isolation.

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Patterns of masochism: an empirical study

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Masochism, a central concept for both theoretical and clinical purposes, is surrounded by confusion which is as widespread as the use of the term. Originally coined by Krafft-Ebing from the name of an Austro-Hungarian novelist (Ludwig von Sacher-Masoch, 1835-95) whose works featured tortured heroes, it was first applied to the masochistic sexual perversion. Freud (1924) broadened its usage to the self-sacrificing characterological form which he called 'moral masochism'. In the succeeding 45 years the broadening process has continued so that now, in its adjectival form, masochism refers to a wide range of phenomena in human beings related in different ways and to different degrees to the central idea that pain gives pleasure. The definition given in *Webster's Seventh New Collegiate Dictionary*, 'abnormal sexual passion characterized by pleasure in being abused by one's associate; broadly: any pleasure in being abused or dominated', succinctly captures this enlargement of meaning.

Psychodynamic understanding of the functions of masochism (or, more properly, *masochisms*) has been similarly elaborated. As Brenman (1952) demonstrated, masochism serves a variety of functions in psychic life. Unravelling masochistic behaviour reveals a skein of instinctual, defensive and adaptive operations which vary in emphasis in different individuals.

The basic definition of masochism implies a link between pain and pleasure, particularly sexual pleasure. Thus it emphasizes the instinctual functions of masochism. The

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common observation that certain people behave as if they craved pain has been the basis of a number of theoretical considerations of masochism. These attempts to understand masochism as an expression of instinct, or as part of an instinctual amalgam, have led to confusion and misunderstanding. In contrast, a careful dissection of clinical observations makes it clear that the best way to understand the behaviour of patients is to consider the defensive and adaptive functions of masochism. This is reflected in the literature in which most papers reporting clinical material interpret it in defensive-adaptive terms.

PURPOSE OF THE STUDY

Considering masochism as a defensive-adaptive operation helps to simplify it to some extent. Nevertheless considerable confusion remains since the different defensive aspects of masochism have not been distinguished from one another in a systematic way. In order to take a first step in this direction, we decided to study and objectify these various defensive functions in the hope of delineating patterns of masochistic behaviour.

On the basis of our clinical experience and the literature, we sketched four areas in which masochism serves defensive functions.

1. In *object relations* masochism serves to retain the object by self-sacrifice and personal subjugation. 'I would rather be mistreated by you than have you leave me' is one way of putting it. There is usually a tenacious control of the object hidden in this behaviour. Both the object and the amount and nature of the punishment administered by the object are dictated by the sufferer. There is

great variation in the degree to which the masochist seeks out suffering. At one end of the scale is the relationship in which the masochist *accepts* mistreatment from the object who is clearly loved for other reasons; at the other extreme, the masochist *actively seeks* an object who will be sufficiently punitive to be satisfying.

There is also variation in the reality of the suffering. Some masochistic relationships consist primarily of fantasied beatings and mistreatment. In others the punishing object must be real and must administer real mistreatment.

2. Masochistic behaviour as a *defence against aggressive impulses* is commonly observed. In one form, denial and projection lead to: 'Look how people mistreat *me*, it is not *I* who am aggressive'. In another form, special conditions permit the aggression: 'I can only get angry when someone has pushed me too far'. Although objects are involved in both cases, the emphasis is more upon handling aggression than upon preserving the object. Guilt and reaction formation often support this configuration.

3. A third area is that of the *enjoyment of pleasure*. Unconscious guilt, or its conscious derivatives, may be so powerful that no pleasure at all is allowed. In other cases, unpleasure or some form of suffering is a necessary condition for pleasure to be experienced. The wife who can only enjoy sex after provoking an argument with her husband is an example.

4. The fourth area in which masochism serves defensive purposes is that of narcissism. The relationship is complex since narcissistic dividends may accrue in any of the first three areas. In some cases the person is unable to admit any pride in himself at all. Often suffering is a condition for allowing narcissistic gratification. The pure form is 'I am good because I have suffered so much'. In relation to objects there are two main forms: 'I am better than you because I have suffered' and 'You are bad because you treat me badly and I am good because of it'. The

form related to aggression goes: 'I am good because I am not aggressive, and am not aggressive because everyone does things to me'.

We decided to use these four areas as the basis of a study of masochism. The study consisted of the following steps: (1) Development of a questionnaire to objectify the concept of masochism. (2) Collection of a group of subjects referred to us as 'highly masochistic'. (3) Intensive clinical interviews designed to learn in detail about the subjects' masochism with the aim of developing subtypes. (4) Use of questionnaire scores to verify differences between clinically derived subtypes.

METHOD

Development of questionnaire. We made up 100 true-false statements which we felt portrayed masochistic attitudes. They were drawn from our clinical experience with masochistic patients and from the literature. The items could be roughly grouped into four categories corresponding to our four defensive areas of masochism: object relations, aggression, pleasure and narcissism.

The questionnaire was administered as part of the intake routine to 300 patients admitted to the in-patient service or the psychiatric out-patient clinic of the New England Medical Center Hospital. The group was heterogeneous, including almost all diagnostic categories and a wide range of ages, socioeconomic classes, etc.

Scores on the 100 true-false items were inter-correlated for the first 146 unselected psychiatric patients (of the total group of 300) and factor analysed using a principal factor analysis and Varimax rotation. Ten rotated orthogonal factors were retained as they seemed clinically interpretable and accounted for 81 per cent of the variance. Items loading 0.30 or higher were retained on a factor. A procedure using the squares of the factor loadings as weights was employed to obtain modified factor scores on each of the 10 factors for all subjects. These factor scores were scaled to yield scores with a mean of 50 and a standard deviation of 10 (*t* scores) for 300 unselected psychiatric patients.

The questionnaire was then administered to a new group of 26 highly masochistic subjects who were specially selected as described below.

Scores on all 10 factors were obtained for each subject. Subjects were divided into groups based on clinical data derived from the interviews to be described. Significant mean differences between factor scores for these groups would be a finding which would provide an independent demonstration of the validity of the clinical categorization of patients.

Subjects. We were interested in a subject group made up of individuals with a high density of masochistic characteristics. All psychiatric personnel in our department were alerted to make referrals to us when a particularly outstanding masochist was encountered. We allowed them to use their own conceptions of 'highly masochistic'. Referrals came from three sources: (1) Patients seen in psychiatric consultation in our general hospital. (2) Patients seen at intake in our psychiatric out-patient clinic. (3) Patients in treatment with one of the authors. In a period of 7 months, this procedure resulted in 26 subjects for the present study.

Interview. A semistructured interview lasting between 1 and 2 hr. was given to all 26 subjects. Two people did the interviewing (M. S. and A. C.). The interviews were designed to elicit specific material on five major categories: aggression, pleasure, narcissism, object relations, and behaviour in the interview. Data were recorded on a protocol sheet by the interviewers. Patients who were in treatment were not interviewed. Instead, their protocols were filled in by the therapist.

Interview protocols were summarized by the research team. The data, compressed into several sentences for each subcategory, were mounted on a large chart. This made it possible to identify patterns within and among subcategories, resulting in the formation of groups based on the clinical data.

RESULTS

Interview. Fifteen of the 26 subjects could be classified in three groups on the basis of analysis of the interview data. The groups were named according to their most salient characteristic as Victims (seven patients), Doers (five patients) and Somatizers (three patients).

The remaining 11 patients of the total group of 26 fell clearly into no category. A number were transitional types between

two of the three main categories. Others could not be categorized at all.

1. The Victims were individuals with an intense relationship with someone who mistreated them physically or emotionally. They were preoccupied with their suffering and occasionally took pleasure in demonstrating it by enthusiastic complaints. With the interviewer they were engaging, personable and seemingly cooperative. In subtle ways they aroused the urge to protect or help them. Some provoked a desire to tease in the interviewer. Like all our subjects, the victims had problems in handling aggression. They were aware that they could be angry and were fearful lest they hurt others. The one possible exception was their sadist. With this person they felt more justified in venting their hatred.

In contrast to other subjects, the Victims allowed themselves considerably more pleasure. Sexual enjoyment in particular was open to them, especially if coupled with pain or degradation. While all the masochistic subjects were reluctant to express satisfaction with themselves, Victims were particularly loath to reveal pride. Victims had intense, highly emotional, often colourful, relationships with others. The male Victims saw their fathers as harsh, strong and fearful figures. They felt their mothers let them down. The Victims tended to be more passive and dependent in their relationships. Strikingly absent was an overt emphasis on self-sacrifice or control of themselves or others. Thus Victims had many features of the oral-hysterical personality.

Mrs V., a 40-year-old housewife, sought help for symptoms of depression. In the interview she was intelligent, talkative, and not very depressed. She demanded help but was reluctant to accept recommendations. She complained bitterly but triumphantly about her 20-year marriage to a man who beat and abused her. While she freely said how much she hated him, she never left him because she hated to hurt him. She felt thoroughly entitled to a better life than she had and felt no guilt about her five-year relationship

with a second man with whom she enjoyed a relationship which was both sexual and affectionate.

2. The Doers formed a group with quite different characteristics. The salient feature was an obtrusive, repetitive emphasis upon the altruistic self-sacrifice, self-effacement and reaction formation which were so clearly absent in the first group. In contrast to the passivity of the Victims, the Doers were independent individuals who relied heavily upon activity. And they talked about and demonstrated their goodness in many ways—by being able to do without pleasure, by never feeling angry, and at times, by claiming to have no needs at all.

Extremely uncomfortable with aggression, they could have outbursts only on behalf of someone else who had been hurt. Pleasure was generally proscribed or confined to experiences which give pleasure to others—having a party, cooking. Sex was rarely described as anything but a duty. Doers were proud of doing, of controlling themselves and of getting along with very little.

Their relationships were one-dimensional, and much less colourful than those of the Victims. Relationships were described almost entirely in terms of their doing for the object. They tended to mismanage their lives, and were often under-achievers. If they had a sadist in their lives it was usually someone to whom they had enslaved themselves in an effort to be of service.

In short, the Doers were much closer to the obsessive-compulsive personalities than were the Victims.

Mrs A. was a 61-year-old woman who was referred to the psychiatric clinic because of depression. She described a life of hardship and self-sacrifice but without complaining. As the oldest daughter of an Italian immigrant family, it was she who was forced to care for her younger siblings so that her mother could work in the fields of the family truck farm. Married to a tailor, she had worked into the night with him, after spending the day tending their several children. As an older woman, she helped sick

friends, and tried without success to maintain her helping relationship to her siblings. She denied that she felt bad about her life in any way, and firmly rejected the idea that she might have resentments about her many disappointments.

3. The Somatizers were a small group (three patients) and less clearly differentiated except by their leading characteristic, obtrusive but medically unsubstantiated physical complaints.

In the interview the Somatizers soon irritated the interviewers by their demands. Although concerned about anger, they readily reported outbursts, usually at weak, dependent figures, often their children. Like Doers, the Somatizers would not admit to having much pleasure, particularly in sexual relations. And they emphasized performance and control of impulses as a source of pride. Their mothers were portrayed as cold and indifferent and their fathers seductive yet strict regarding sexual matters. They were like Victims in having had a sadistic object at one time or another.

Questionnaire. Statistical analysis based on scores from the factor-analysed questionnaire clearly differentiated between the two groups of subjects (Victims and Doers) which were derived from clinical interviews. Somatizers, though too few in number for statistical purposes, tended to have scores like the Doers.

On two-tailed *t* tests for small groups, a comparison of the factor scores of Victims and Doers showed differences on five of our ten factors at or beyond the 0.05 significance level.

Doers showed higher scores than Victims on factor I at the $P < 0.001$ level of significance. The statements making up this factor are listed in Table 1. Because of the pervasive theme of misanthropic aggrievement, we named it the Suspicion factor.

Doers' scores on factor II were significantly higher than Victims at the $P < 0.05$ level. In this factor a balancing operation is salient in which one is awarded gratifications of various sorts in proportion to one's suffering.

Table 1. *Factor I: Suspicion factor*

Loading	
0.6	People will hurt you if you don't watch out
0.6	Somehow I often get left holding the bag
0.6	It seems that no one is ever there when I most need them
0.6	People do not seem to be as thoughtful of my feelings as I am of theirs
0.5	Often people are friendly when they want something but drop you when they no longer need you
0.5	People are often disappointing
0.5	I often have to fight my feelings of loneliness
0.5	Often people who are really out to get you act as nice as can be on the outside
0.4	The only person you can be sure of is yourself
0.4	I accomplish more if I do the whole job myself
0.3	When I think I might have hurt someone's feelings, it bothers me for days
0.3	I've learned a great deal from the hard knocks I've had
0.3	I'm afraid that some of my closest relatives take secret satisfaction in my misfortunes
0.3	People seem to be nicest to me when I am sick
0.3	I feel very guilty whenever I find myself wanting something that someone else has

We named it the Balancing factor (see Table 2).

Doers' scores on factor VI were significantly higher than Victims' at the $P < 0.01$ level. Factor VI statements seemed to us to reflect obsessive-compulsive characteristics and we named it the Compulsive factor (see Table 3).

Doers scored significantly higher on factor VII ($P < 0.01$). We named it the Negative Fun factor because of the statements relating to pleasure (see Table 4). Our Doers indicated their reluctance to allow themselves enjoyment by their responses on this factor.

Finally, Doers scored higher than Victims

Table 2. *Factor II: Balancing factor*

Loading	
0.6	He who suffers a great deal will one day triumph
0.6	When children are enjoying their pleasures, they should be reminded that some people don't have as much as they do
0.5	The more a person does for another person, the more consideration he deserves
0.5	Whoever has to bear much hardship, should have pleasures that others do not have to make up for it
0.5	The more a parent gives up for the sake of his or her child, the more consideration he deserves when the child grows up
0.5	The person who suffers deserves more credit than the person who lives a comfortable life
0.5	We should always remember the less fortunate while we are enjoying our pleasures
0.5	He who has to endure torments from another will one day be victorious over his tormentor
0.4	I am a better person for having had to give up a lot
0.4	The more you have to go through for something you want, the more pleasure you will have when you get it
0.4	People who have had great setbacks are better liked than people who have been very successful
0.3	The longer you wait for something, the greater pleasure it will be
0.3	Great men are able to withstand more pain and hardship than other people

($P < 0.01$) on factor X. Statements making up factor X express several ideas—stoicism, duty, forgiveness.

In summary, results of factor analysis are consistent with the clinical observations. They reveal the Doers to be misanthropic, suspicious and aggrieved in their attitudes. They tend to bargain for gratification by suffering and renunciation. Duty, renunciation,

and self-effacement characterize their values and their relationships to other people. They are uncomfortable with pleasure. The general

Table 3. *Factor VI: Compulsive factor*

Loading

0.5	The sight of the unhappiness he has caused someone else makes the most hard-hearted person feel guilty inside
0.4	I try to do the job I don't like to do first before doing what I like to do
0.4	The longer you wait for something, the greater pleasure it will be
0.4	I tend to get more satisfaction when something nice happens to someone I love than when it happens to me
0.4	When I am enjoying myself, I can forget my cares and worries
0.4	I feel satisfied with myself when I do something I don't feel like doing
0.3	The more you have to go through for something you want, the more pleasure you will have when you get it
0.3	I learned early the value of accepting whatever came to me
0.3	People who have had great setbacks are better liked than people who have been very successful
0.3	I have a great deal of admiration for the person who never loses his temper

Table 4. *Factor VII: Negative Fun factor*

Loading

0.5(-)	Sexual pleasure is very important to me
0.5(-)	I enjoy racy stories
0.4	I usually don't try new ways of having fun
0.4	The only time I can ask someone to help me is when I am very sick
0.3	I'm glad I can be satisfied with very little
0.3	I am very frightened by all competition
0.3	Before I can really relax and enjoy myself, I have to feel most of my chores are done
0.3	Whatever else may be my faults, I never knowingly hurt another person's feelings

Table 5. *Factor X*

Loading

0.5	If I can understand why someone is mistreating me, I can easily put up with it
0.4	I enjoy life most when I am caught up on my responsibilities
0.3	When someone does something mean to me, I usually try to excuse him
0.3	I often find I have to prove to others they are expecting too much of me
0.3	I feel that the more a person has, the more he should do for other people
0.3	Great men are able to withstand more pain and hardship than other people

impression is then that Doers have more obsessive-compulsive traits and Victims more oral-hysterical ones.

SUMMARY AND DISCUSSION

In this study we have found three patterns of masochistic behaviour and attitudes. The three groups which show these patterns have different characteristics in interview, and there are significant differences between groups on factor scores derived from an objective questionnaire designed to reflect masochistic attitudes.

The first group of seven subjects we termed Victims because they had an important relationship with a sadistic object. They showed many oral-hysterical character traits including passivity, colourful emotional relationships, a warm relationship to the interviewer and a sense that they were entitled to enjoy themselves.

Five of our subjects were Doers, who were much more active, self-sacrificing, controlled, and duty-orientated than the Victims. Their character traits were more often in the obsessive-compulsive group.

Clusterings of answers to the masochistic attitude questionnaire revealed that the Doers, in comparison with Victims, were more suspicious, balanced gratification and suffering, were compulsive, and eschewed enjoyment in favour of stoicism and duty. Thus the questionnaire content paralleled the interview data.

The third group of three patients, Somatizers, was less clearly differentiated except by its lead characteristic of repetitive somatic complaints.

The purpose of this study was to clarify confusion in the literature and in clinical practice about the nature of masochism. Our results demonstrate that much of this confusion derives from the tendency to view masochism as a single phenomenon. We have shown that it is possible to identify at least two patterns of masochism (Victims and Doers). Clinically these patterns are distinguishable in terms of differences of character traits, attitudes, object relationships and life history. Furthermore, clusterings of answers on a questionnaire designed to reflect masochistic attitudes reveals significant differences between these two groups. At the same time it is clear that the tendency of both groups to take defensive pleasure in being abused or dominated justifies their being considered masochistic.

It is this combination of similarity and diversity which underlies the contention in the literature over the nature and characteristics of masochism. It supports those authors who have emphasized the diversity within masochism (Brenman, 1952; Loewenstein, 1956; Brenner, 1959; Berliner, 1947).

The third group, the Somatizers, is less distinct. Small in size, this group was composed of individuals who showed clinical characteristics which were similar to both Doers and Victims. Their existence as a group is based primarily on clinical criteria and may be an artifact of the salience of their physical complaints.

A final question concerns the interrelationship of these masochistic patterns. Although distinguishable in terms of the methods employed, the question arises: are these categorically different phenomena or are they related to each other on some kind of continuum? The 11 patients who did not fall into clear-cut categories provide us with the answer. Two of these patients were quite clearly transitional types between Doers and Victims. While emphasizing their devotion to duty, denial of pleasure, and service to others, these two patients also had currently or in the past had relationships with punitive, sadistic objects. Two other patients were Doers with pervasive and dramatic physical complaints.

Although the numbers are too small to construct a detailed continuum, the existence of these transitional types clarifies the nature of the phenomenon.

Finally, a comment about the relationship to character typology is in order. It is striking that the Victims have so many oral-hysterical character traits while the Doers seem more obsessive-compulsive. Loewenstein (1956) pointed out that masochistic fantasies take different forms depending upon developmental level. At the oral level the fantasy is of being devoured, at the anal level of being beaten, and at the oedipal level of being castrated. Our work does not tap a level of personality which would allow us to make statements about the nature of the masochistic fantasy. However, it is clear that the form which the masochism takes is a consistent reflexion of the personality traits in our patients which are outside the masochistic area. For instance, the masochistic style of the Doer in doing for the other person in order to be good and not aggressive or harmful mirrors the obsessive-compulsive style which is so prominent in the rest of their personalities. Equally, the masochistic style of the Victims which is to be set upon by a fierce, exciting love object is consistent with the flamboyant, hysterical traits which these individuals show.

It is unfortunate that clarity in considering complex human phenomena often carries the surcharge of an increase in jargon and neologisms. In the present case the price for an awareness that there are at least two (and probably several more) patterns of masochism is that it may be necessary to speak of 'Victim Masochists' and 'Doer Masochists'. The results of our study indicate that such a burgeoning of terminology would lend precision to the study of masochism.

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Conjoint marital therapy and the prisoner's dilemma*

BY F. J. ROBERTS†

A monadic view of psychological disorder entails forms of psychotherapy and other treatments which have been increasingly criticized (Truax & Carkhuff, 1967), whilst an interactional view entails, amongst other things, the technique of conjoint marital therapy. This view, which is described by Hooper & Roberts (1967), emerges out of the work of a number of people. Perhaps the main exponent of an interpersonal account of psychiatry was H. S. Sullivan, who up until his death in 1947 worked in the belief that psychiatry's 'peculiar field is the study of interpersonal phenomena' (1938). Although an analyst by training, he brought the ideas of G. H. Mead and A. N. Whitehead to bear on clinical problems (1953). Others, most notably von Bertalanffy (1962), have described biological phenomena in terms of systems, which provides a powerful model to think about behavioural problems. He introduced the idea of 'general systems theory', which makes it possible to think in the same way about such diverse phenomena as a community of mammals and homeostatic biochemical processes. This theory now finds support and application in such different fields as engineering, communication technology and computer science as well as biology and psychology.

Laing *et al.* (1966), Lederer & Jackson (1968), Mishler & Waxler (1968) and Watzlawick *et al.* (1967) have all relied on an interactional or systems model when thinking about psychiatric disorder and treatment. In their own ways they have indicated their dissatisfaction with conventional psychiatric thinking which attempts to consider an indi-

vidual as being largely isolated from his everyday environment.

Barker (1968) has argued that what he calls 'behavioural settings' are 'stable, extra-individual units with great coercive power over the behaviour that occurs within them'. For our purposes we regard marriage as the most important 'behavioural setting' in which the lives of our patients are worked out. Therefore in taking an interactional view we recognize the power within the system of marriage for both sickness and health.

Like the majority of biological systems, marriage is 'open' in that there is a relatively stable equilibrium within the system with each component influencing the behaviour of the other, but at the same time the system as a whole is open to outside influence. For our purposes there are two important parts of general systems theory. First, there is information theory, which concentrates on the nature of messages and their sending and receiving. Secondly, games theory is concerned with the strategies available to players so that predictions can be made of both the behaviour of the players and the outcome of the game. Marriage is an example of a game with its own rules. These two aspects can be applied to the problem of understanding and treating psychiatric conditions within the system of a marriage.

We will now consider the example of one particular system as seen in a marriage, together with its idiosyncratic methods of communication and the strategies employed by each partner. The couple came into treatment after the husband had presented with a fairly severe depression. He was a physician who had been married for 10 years. They had a daughter aged four and the wife was now nearing the end of her second pregnancy. They were

* Based on a paper given to the Psychotherapy Section of the R.M.P.A. on 14 January 1970.

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initially seen by themselves and then together when the idea of conjoint therapy was offered to them. At first they were rather bewildered by the idea, but eventually agreed to give it a trial.

At the outset of conjoint therapy the wife made her attitude to the procedure clear by asking how she should handle her husband. They seemed ill at ease with each other and at the end of the session they indicated some reluctance to continue.

At the second session it was apparent that something had happened. Their relationship now appeared congruous although he was now very much more depressed, waking at 3.30 a.m., was impotent and expressing desperate feelings. His wife was clearly in control and she was concerned about the jealous ideas he was talking about concerning their daughter.

A 3 week break occurred in the conjoint treatment due to the wife's confinement and during which his condition remained unchanged.

Despite being a skilled physician with sophisticated pharmacological views, he insisted on his second attendance on starting on an antidepressant. He did so because the drug was called *antidepressant*, while at the same time he acknowledged that the evidence that it had a specific antidepressant action was of a very low order. Throughout the remainder of the treatment he manipulated the dose himself and at the end admitted that the outstanding effect of the drug was to cause him severe constipation.

We resumed our conjoint sessions and the wife announced that things were better as she now had the *three* children well in hand. This led to a discussion of the various roles they each played within their family. We talked about the wife's motherly role and the way in which after the beginning of treatment he had lost his role as husband and had become a son. His feelings of jealousy had now extended to include his son, especially at times when he was being suckled. We discussed the importance of the roles in the

marriage, their expression and working out in their relationship and the onus on each for their implementation. The wife's parting comment in this session was to the effect that they were really responsible for the way in which their lives went.

After a week it was clear that the wife had been trying for most of the 7 days to be a wife rather than a mother. He in return had behaved petulantly, insisting that he was the ill one and so deserved special consideration. The wife declared that she had found the week difficult as his response to her had not been appropriate; this left her feeling hopeless and depressed. We rehearsed again the significance of their behaviour together.

At the fifth session the wife was depressed and angry. By contrast the husband, although still depressed, was jubilant in a self-righteous way. He attempted to avoid discussion of the interaction and insisted on talking about the need for a wholehearted pharmacological approach to his depression and how a new powerful effective antidepressant was needed. The wife changed the subject and told how he had imported his widowed mother to stay with them on the pretext that she could help his wife. This was discussed in terms of the way in which he had had his role as son confirmed. We tried to formulate a plan in which the mother could be asked to leave. He made it clear that he expected his wife to ask the mother to go. When she refused he sought my intervention in their home to get rid of mother.

By the penultimate and sixth session they had arranged for mother to leave in a way which left no ill feelings. This was the turning point in their treatment as now they were able to fulfil their appropriate roles *vis-à-vis* each other and their children. Within a few days of mother's departure they had lost their symptoms and were responding as husband and wife and were again enjoying a satisfactory sexual relationship.

It would be wrong to think of treatment in this context as something which just happened once a week for 1 hour. Because it was con-

Conjoint marital therapy the therapeutic changes which were explored during the therapy session were examined and practised for the period between sessions as the partners gradually accepted responsibility for what occurred.

This case illustrates the way in which the interactional view of psychological disorder could at least have had a pragmatic relevance for this couple.

Our experience has been that the same kind of technique is applicable over a whole range of disorder. By and large no attempt is made to diagnose the conditions according to a conventional classification, although in this example endogenous depression (Kiloh & Garside, 1963) would have been the label attached to the husband and puerperal depression that for the wife. Instead the emphasis is always placed on defining the characteristic system of each couple.

It may be objected that the *real* treatment in this case was the amitriptyline. In view of the worsening of his condition at the time when he should have shown some signs of improvement, the overall delay, in effect 6-8 weeks, after reaching what is usually thought to be a therapeutic dose and his own final conclusion about the drug, this type of explanation is at best unconvincing. A preferable account will concentrate on those events within the marital system which correlate with recovery rather than the speculative events in some physiological system.

Although some idea of the actual technique may have been gathered from the description of the case given above, it is important to set it out in some detail in order to show how the actual theory relates to the practice.

The first interview follows the conventional pattern except that the idea of the importance of the spouse in both assessment and treatment is introduced. The spouse is interviewed with the patient's consent and the couple are then interviewed together. No attempt is made at this stage or subsequently to highlight the differences which are revealed between the three interviews, but these are

exploited in so far that they help to ways of understanding the couple's interaction.

There are three short-term goals during the conjoint sessions. The first is an account by each of how they see their own role in marriage. This can be achieved in increasingly sophisticated terms progressing from husband and wife, wage earner and homemaker, to the dependent or supportive partner. It is then important to delineate the way in which the psychiatric condition has distorted the original pattern of interaction. This is necessary as couples usually start by talking about their roles as they are in normal times. It is important to get each to say how they see both their own and their partner's role. Consideration of roles is only an introduction to looking at the way in which the couple communicate. In talking about their roles they begin to reveal the implicit messages of certain types of behaviour which can then be explored.

The next goal is to define the needs of each within the relationship as seen by each for themselves and the other. Again this can lead to an examination of the way in which the couple communicate.

At any stage either spouse may object to the procedure on the grounds that it has little to do with reasons for which they began treatment. Questions are asked such as 'what about my depression?' as we saw in the above example. The significance of the timing of these queries is usually obvious in the light of the implication of the preceding events, again as we saw above.

During treatment the next goal becomes apparent as each talks about the areas within their relationship for which each predominantly has responsibility. There are, of course, areas for which they will share responsibility. Even in the extreme case where some who are very dependent complain that they are without any responsibilities at all, the complaint can be demonstrated as untrue simply by considering mundane events in their lives, for example eating or lovemaking together. Once there has been a mutual recognition

of these responsibilities, particularly of those things which have a real bearing on the basis of their marriage, it is possible to examine why each does not implement those perhaps simple changes which would result in an improvement for them both. At this stage it becomes clear that the couple are caught in a situation which they both dislike because both are in some sense handicapped within the situation. It is paradoxical that while they *feel* trapped they both acknowledge that some changes are theoretically possible.

This, then, is the crucial question which emerges from this kind of work; how can we conceptualize what is happening in an interaction—where both partners are handicapped, wanting change, have the ability to change and yet remain as they are—so that we can understand and intervene to bring changes to the advantage of both?

In marriages where one partner has psychiatric symptoms and may thus be labelled as depressed, anxious or paranoid, the conventional practice is to regard this spouse as disproportionately handicapped when compared to the other spouse; this is to misunderstand the nature of the handicaps within the system for each of them. It is only by considering the pattern of communication that we can begin to see the reciprocal nature of the interaction and the way in which changes can be made. To the extent that each partner in the interaction can choose between various possibilities when communicating can changes occur.

This underlines two aspects of general systems theory mentioned above. Communication theory suggests that there are at least two parts to all messages. They can be thought of as the report and command, or the content and relationship aspects. The former contains the data, e.g. 'I love you', while the latter classifies it emotionally. This latter is non-verbal and is conveyed by tone of voice or posture or facial expression. The former is often called the digital information, while the emotional qualifying aspect is called analogic and is or is not congruous with the

digital part of the message (see Watzlawick *et al.*, 1967).

The notion of choice introduces the second important part of general systems theory for psychotherapy: games theory, which is exemplified by the 'prisoner's dilemma'.

The actual prisoner's dilemma occurs in the situation where two men are apprehended for a comparatively trivial offence by the police, who come to suspect them of being involved in a much more serious affair. The prisoners are placed in separate cells, so they cannot communicate with each other. The investigating officer goes to each and says: 'We have got you for the trivial offence, but since I have talked with your colleague I know that you were concerned as well with this serious affair. If you tell the truth, then I shall do all that I can to see that you get off lightly because you have cooperated with us. If you continue to deny the second charge, then I am afraid you will be given a most severe sentence.'

		Prisoner A	
Choice:		Silence	Talk
Prisoner B	Silence	A 1 A	DD 2 d
	Talk	d 4 DD	D 3 D

Fig. 1

Each prisoner is faced with the dilemma: does he talk or remain silent? If he remains silent and his colleague remains silent then they will both be equally and lightly punished. If one of them talks and the other remains silent, then the talker will be punished, but not to the same extent as his colleague or to the same extent as both of them should they both talk. If he can trust his colleague it would be best for him to remain silent; if he cannot trust him then he should talk, as there is always just a chance that he will benefit disproportionately should his partner remain silent. The reverse is true should he remain silent and his colleague talk. This can all be set out in the form of a matrix (see Fig. 1).

The outcome for each choice is represented in the four quadrants in the matrix. The outcome for Prisoner A appears in the top right half of each quadrant and that for Prisoner B in the bottom left half. A and D represent respectively advantageous and disadvantageous outcomes, while DD is a disproportionately disadvantageous outcome and *d* is where a prisoner is only relatively disadvantaged. It can be seen that quadrants 2, 3 and 4 are all unfavourable and in each both are handicapped as far as their activities together are concerned.

terms of the way in which they played out various kinds of role *vis-à-vis* each other. In so far as they were able to choose how they behaved and they were *unable* to communicate with each other in a manner which enabled them to resolve their relationship problems they could be thought of as being in a similar position to the prisoners in the dilemma situation.

The choices which were open to this couple lay mainly in the way in which they treated each other, thereby partly determining the kind of behaviour in the other which they

Choices:		Husband to behave as a husband or son	
Wife to behave as a wife or a mother	a wife	1 <i>A</i>	2 <i>d</i>
	a mother	4 <i>DD</i>	3 <i>D</i>

Fig. 2

There is a striking similarity between the plight of the prisoners and that of couples in conjoint therapy. It can be argued for a couple that metaphorically each is in a cell as they *cannot communicate with each other* in a manner which allows them to trust each other and escape from the dilemma. The purpose of the conjoint therapy is to open up useful communication again.

Watzlawick *et al.* (1967) point out that the characteristic of a disordered relationship is the way in which the couple are preoccupied with the relationship or analogic parts of their system rather than with the digital information. The same is true of those marriages in which one of the couple is regarded as psychiatrically ill. The paradox is that in their efforts to communicate and reach some resolution the couple will attempt to effect some change by negotiating with the digital messages alone while at the same time they remain trapped by the ambiguous or incongruous analogic communication.

In the case of the couple whom we have considered above, we found that the analogic messages were most easily thought of in

would find acceptable. In the case of the wife she could behave as his wife or as if she were his mother. The husband could either be her husband or he could behave as her son. These roles do not, of course, preclude there being other possibilities open to them both.

We can now construct a matrix (Fig. 2) for this couple and follow through the various changes which occurred during treatment.

When the couple first came for treatment the husband was struggling to maintain his behaviour as husband while the wife was acting as a mother towards him. As can be seen in the matrix this places them in quadrant four. This situation was to the relative advantage of the wife as she had control over the situation. At an early stage in treatment he lost the struggle and behaved as a son, so moving them into quadrant three. In some ways this was a more stable situation than either quadrant two or four, largely because their messages were now congruent but their situations were equally handicapped as they were each excluded from the rewards which stem from a husband-wife relationship. It is this relatively stable situation in which this

and other couples have described how they feel trapped while at the same time acknowledging that to some extent they could see the changes which were necessary for them to move to a more satisfactory and satisfying way of life. While in this situation we were able to explore together the various messages which were implicit in the roles which each had been playing and the changes which were required of them both. The first to change was the wife, who attempted to return to her wifely role again. The husband was placed by this move in an advantageous position in that he now controlled the general tenor of their interaction and she was disproportionately discomfited. They were then in quadrant two. The wife responded to the disadvantage by becoming depressed. His next move was to import his mother in order to maintain his position in the face of his wife's persistence in being a wife. Release from the persisting dilemma occurred when he began again to behave as a husband.

From the point of view of the therapist, the games theory analysis of the marital interaction enables the very complex data to be handled in an orderly manner. It provides the frame on to which can be worked the short-term goals which were detailed above. Perhaps the most important single attribute of this way of conceptualizing the problem, for on it hangs the therapeutic key, is that it can enable the therapist and also the couple to see that what prevents them moving from the relatively stable situation in quadrant three is, first, that the partners usually fear the distress and imbalance of the second and fourth quadrants and, secondly, and what is most important of all, that trust is required in order for them to reach a satisfactory solu-

tion. It is not necessary to spell out for the couple in a formal way the games theory as a description of the possibilities in their own situation is quite adequate. The implicit 'I will if you will' which usually emerges during therapy when the couple are in the dilemma needs to be made quite explicit. If the couple could take the necessary action together then they would be able to move directly from the situation in which they are equally handicapped to that where they are mutually rewarded, i.e. move from quadrant 3 to 1.

Another advantage of this formulation is that it raises those important issues in which there is some chance of change on to a non-biochemical level. This is important because any biochemical considerations place the matter outside the hope of control by the couple concerned. There is an inevitability about biochemical things which can distract the couple from those issues for which they can truly be responsible.

Once the level of intervention and concern is on an interactional level it is still possible to run foul of the rock Scylla which counsels a kind of Stoic moralism with 'pull yourself together' and 'it is just up to you' or that of Charybdis which places the main determinants of behaviour in the inaccessible regions of the unconscious.

The prisoner's dilemma is part of everyone's experience and is clearly illustrated by those things which happen within marriage. At times the dilemma can reach such proportions that choices are made to the detriment of the couple. By focusing therapy on to the interaction within the relationship and the dilemmas which face the couple, a therapeutic method can be formulated and, following their trustful cooperation, implemented.

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A parsimonious theory of overinclusive thinking and retardation in schizophrenia

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Chronic schizophrenics have been described by Payne (1961; Payne *et al.*, 1963) as retarded but not overinclusive in their thinking, a fact which has led him to suggest that over-inclusiveness may indicate a good prognosis. An alternative explanation, equally viable in the absence of longitudinal studies of the same patients, is that acute schizophrenics who are overinclusive learn to cope with their attention defect by slowing the rate at which they respond to stimuli (Romney, 1967).

Payne & Hewlett (1960) found that acute schizophrenics were very heterogeneous on the overinclusion and retardation factor scores derived by them. While, as a group, the schizophrenics were differentiated from the depressives in terms of their overinclusion factor scores they were not different from the depressives with regard to retardation. While the correlation between overinclusion and retardation factor scores was negligible for the total group, it appears that a significant negative relationship may obtain in acute schizophrenics. When the ten schizophrenics whose 'retardation' factor scores fell outside the normal range were compared with the seven whose scores were within this range it was found that the ten abnormally retarded schizophrenics had an average 'overinclusion' factor score nearly identical to the normals. On the other hand the seven schizophrenics whose 'retardation' scores were all within the normal range had a mean 'overinclusion'

score considerably higher than the normals or retarded schizophrenics.

Payne & Hewlett suggest that there may be two groups of schizophrenics, one resembling endogenous depressives in that, while not abnormally overinclusive, like depressives they are retarded. The second group, unlike depressives, suffer from an abnormal degree of overinclusion. While slightly retarded their slowness is due to their overinclusion which causes them to over-elaborate most tasks.

The experimental evidence with regard to the relationship between overinclusion and retardation is conflicting, due no doubt in part to the different tests of overinclusion and retardation that have been used. Foulds *et al.* (1969) found that the correlations calculated between various tests of schizophrenic thought disorder, including the object classification test and the modified proverbs test (Payne & Friedlander, 1962) and speed measures derived from the Babcock-Levy and digit symbol tests tended to be negative, though statistically insignificant. By contrast Payne & Caird (1967), examining the relationship between overinclusion, retardation and reaction time performance, found that overinclusion, as measured by the modified proverbs test, and retardation were positively, though insignificantly, correlated.

There are, however, a number of observations which suggest that some schizophrenics are unable to cope with situations in which they are required to respond quickly but are able to perform appropriately if the required rate of response is slowed or brought under their control. Payne (1953), in an experimental study of a single schizophrenic, was able to show that the patient's thought disorder could be manipulated by varying the social

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pressure to respond. Shakow (1962) has suggested that part of the schizophrenic's problem may be that of pacing. Where schizophrenics set their own pace on a tapping task, Shakow found that their performance was as good as that of normal subjects. When the pace was set by the experimenter schizophrenic performance deteriorated. Storms *et al.* (1967) found that schizophrenics under pressure to respond became even more unstable in their associations to stimulus words. Court & Garwoli (1968) have suggested that the schizophrenic's breakdown in data processing occurs when the pressure to respond appropriately exceeds an optimum level. Payne *et al.* (1970) found that if they employed the rate of presentation used by Moray (1959) their schizophrenics were unable to shadow a message even in the absence of interference. The slow and variable reaction times shown by schizophrenics as a group is further evidence of their inability to respond quickly.

That normals have an optimal rate of responding which if surpassed results in errors typical of those made by schizophrenics at a slower rate is illustrated by an experiment carried out by Usdansky & Chapman (1960). Usdansky & Chapman found that if normals were subjected to time pressure in sorting the Chapman Card Sorting Test they made schizophrenic-like errors, i.e. errors resulting from associative distraction. Flavell *et al.* (1958) found that normal subjects completing a word-association test under time pressure gave responses similar to schizophrenics. Miller (1960, 1964) has shown that if normals are forced to respond at ever-increasing rates they adopt strategies of grouping which bear some resemblance to schizophrenics' disordered reproductions.

That schizophrenics appear thought-disordered in a variety of tests which are not timed is probably due either to the fact that they have not learned to cope with their attention defect by slowing the rate at which they respond or to the fact that even if they have learned this adjustment they nevertheless

complete the test as if it had to be done as quickly as possible.

The evidence reviewed above suggests that schizophrenic distractability and retardation are reactions to the same basic condition of information overload. A similar formulation has been proposed by Broen (1968). Acute schizophrenics are aware of a diversity of stimulation, much of which is disregarded by normals (McGhie & Chapman, 1961). At this stage schizophrenics do not appear, however, to be retarded; rather they attempt to cope with this diverse stimulation and as a result appear distractable and disordered in their thinking. What is proposed here is that at some stage of their illness schizophrenics may learn to cope with their condition of stimulus overload by reducing the rate at which they respond. To the extent that they are successful they no longer appear overtly distractable. They will, however, appear retarded on psychomotor tasks.

The evidence of Payne and his colleagues would suggest that if a group of schizophrenics are given tests of overinclusion and retardation some will be found to be over-inclusive but not retarded while others will be found to be non-overinclusive but retarded. The model proposed here would predict that slowing the rate of responses of the former (overinclusive but not retarded schizophrenics) would reduce their overinclusiveness, while increasing the rate of response in the latter (non-overinclusive but retarded schizophrenics) would result in their becoming more overinclusive. Such an experiment has the virtue of employing subjects as their own controls and testing two independent predictions from the same theory. The study reported here represents a pilot investigation conducted on these lines.

THE SUBJECTS

The subjects were 20 patients (14 males, six females) all of whom had been unequivocally diagnosed as schizophrenic. There were 13 short-term patients with a mean period of hospitalization of 0.3 years (S.D. 0.18 years) and seven long-

term patients with a mean hospitalization of 11.6 years (S.D. 4.71 years). Fifteen of the patients were classified as chronic and five as acute. Individual data on all the subjects are given in the appendix.

The mean IQ of the group on the Mill Hill Vocabulary Scale was exactly 100 (S.D. 11.09) and the mean age was 31.95 years (S.D. 9.83 years).

While no patient was included in the study who had received psychosurgery or insulin coma therapy or who had undergone electroconvulsive treatment in the previous month, all were on some form of medication, mainly phenothiazines. Court & Garwoli (1968) found that a group of patients on phenothiazines were not differentiated from a drug-free group on a choice reaction-time task though the variances of the group of patients on drugs were significantly larger in three of the four situations. In a study employing a number of tests derived from the Babcock Mental Efficiency Battery (Babcock & Levy, 1940) Shapiro & Nelson (1955) concluded that the level of sedation did not account for the differences found between abnormal groups, nor did the drug effect account for the differences found between normal and psychiatric groups. Payne *et al.* (1963) investigated the effect of Proketazone, a high potency phenothiazine, on the overinclusion test performance of a group of chronic schizophrenics. However, as the chronic schizophrenics tested were not found to be overinclusive when off drugs the effect of Proketazone on overinclusiveness could not be ascertained. Payne has suggested elsewhere, however (Payne, 1968), that drugs of the phenothiazine type should reduce overinclusiveness in acute schizophrenics. If this were the case the schizophrenics tested in the present instance might be expected to get higher scores on the test used under drug-free conditions.

A more adequate test of the model proposed here would need to consider both drug effects and those dimensions of schizophrenia which have proved significant correlates of performance on a number of cognitive tasks (e.g. paranoid/non-paranoid; process/reactive).

THE TESTS

Overinclusion. The measure of overinclusion employed was the number of associative errors made on the Chapman Card Sorting Test (Chap-

man, 1958). This test requires subjects to sort cards bearing the names of common objects according to an equal number of guide cards, each of which has the names of three objects on it, choosing the one guide card word belonging to the same conceptual class as the sorting card word. The three names on each guide card illustrate a correct concept, an associated but inappropriate concept and an irrelevant concept. The associated concepts are either based on contiguity of objects (e.g. nose-handkerchief), contiguity of words (e.g. suit-case) or rhyme (e.g. barrier-carrier). The order in which the words appeared on the guide cards was randomized. Each subject was given six practice sortings before starting the main test, during which he was asked to explain his sorting and given assistance if necessary.

Forty-five cards were randomly selected from a total deck of 90 cards for each of the two trials with the proviso that in each trial there was to be an equal number of each of the three types of associated concepts. The order in which cards were presented to individual subjects was determined randomly.

Retardation. The measure of retardation employed was the time taken to complete the Babcock Digit Substitution Test (Babcock, 1941). This test requires a subject to insert numbers in figures of different shapes using a standard key.

PROCEDURE

All subjects were initially tested on both the card-sorting and digit-substitution tests. The card-sorting test was completed in the first instance at the subject's own pace and without any reference to time, though the total time taken was in fact unobtrusively recorded. The digit-substitution test was administered according to Babcock's (1941) instructions and the total time taken recorded. All subjects were then classified as overinclusive or non-overinclusive according to whether they obtained an associative error score of 11 or more on the card-sorting test. This score, which is similar to the mean obtained by Chapman's (1958) schizophrenics, divided the group into two equal subgroups of 10, matched in terms of intelligence, education, age and years of hospitalization.

All subjects were then required to complete the card-sorting test a second time under either slowed or speeded conditions according to whether

they were classified as overinclusive or non-over-inclusive respectively on the initial trial. The two trials occurred on the same day. Subjects who were slowed were told that they had been too fast on the first trial and were now required to take their time. At the 10th, 20th and 30th card subjects were reminded to take their time and consider each alternative before sorting the card. Under the speeded conditions subjects were told that they had been too slow on the first trial and that they were to work as quickly as possible and that they would be timed. A stopwatch was clicked frequently and subjects made aware of the timing; in addition, on the 10th 20th and 30th card subjects were urged to go as fast as they could. In order to check the effectiveness of these instructions the total time taken on the second trial was recorded, unobtrusively in the case of those who were slowed. Care was taken to ensure that the experimenter did not vary the rate at which he presented the cards from condition to condition.

The scores obtained by the overinclusive and non-overinclusive schizophrenics on the card-sorting test and digit-substitution test under unpaced conditions are given in Table 1.

inclusion score obtained from the card-sorting test was positively though insignificantly correlated with the measure of retardation (+0.106). While previous studies provide only inconsistent and tenuous evidence for the predicted negative relationship between overinclusion and retardation it had been expected that, in a sample of schizophrenics characterized as overinclusive or non-overinclusive, a significant difference in retardation would be found. Whatever the explanation the fact that overinclusion and retardation are insignificantly related in the present sample to some extent invalidates the hypothesis under consideration.

The number of associative errors made on the card-sorting test correlated significantly with length of hospitalization (-0.376 ; $P < 0.05$) as suggested by Payne's work and required by the present theory. While the retardation score derived from the digit-substitution test had only an insignificant correlation with length of hospitalization the time taken to complete the card-sorting test under paced conditions correlated positively with length of hospitalization (+0.440; $P < 0.05$).

Table 1. *Characteristics of the overinclusive and non-overinclusive schizophrenics and their mean performance on the digit-substitution and card-sorting tests under unpaced conditions*

	IQ	Education (years)	Age (years)	Hospital- ization (years)	Digit- substi- tution test (sec.)	Card-sorting test	
						Associative errors	Time (sec.)
Overinclusive schizophrenics ($n = 10$)	99.3	10.8	29.5	1.8	139.2	22.9	426.6
S.D.	10.4	2.1	8.9	4.3	61.4	3.8	167.2
Non-overinclusive schizophrenics ($n = 10$)	100.7	11.8	34.4	6.8	133.4	5.0	540.5
S.D.	12.3	2.3	10.5	6.4	68.9	3.2	270.1
t values	0.27	1.02	1.12	2.02	0.2	11.33	1.13
	n.s.	n.s.	n.s.	n.s.	n.s.	$P < 0.01$	n.s.

While as would be expected the two subgroups were significantly differentiated on the over-inclusive measure obtained from the card-sorting test, contrary to prediction they were not differentiated in terms of the time taken to complete the digit-substitution test nor were they differentiated in terms of the time taken to complete the card-sorting test.

Contrary to what had been supposed the over-

Despite the failure to find a significant negative relationship between overinclusion and retardation the overinclusive group was slowed and the non-overinclusive group speeded on the second trial as had been intended.

That the differential instructions were successful in speeding or slowing performance on the card-sorting test is indicated by the fact that overinclusive subjects were significantly slowed

the time they took to complete the card-sorting test on the second trial and the non-overinclusive subjects significantly speeded. As predicted, the overinclusive subjects were made significantly less overinclusive and the non-overinclusive subjects significantly more overinclusive on the second trial. It was the associative error score and the number of correct sortings which were affected by the instructions. Very little change occurred in the number of irrelevant sortings made under either condition. That it was the differential instructions and not merely practice which produced these differences was shown by an analysis of variance performed on the overinclusion scores in which occasion of testing proved an insignificant source of variance and group \times trial a significant interaction effect.

inclusive but not retarded and those four patients who were retarded but not overinclusive. A score of 109 sec. on the digit-substitution test was adopted as the cut-off point defining retardation. This score is in excess of the mean score obtained by Payne & Hewlett's (1960) acute schizophrenics on the same test. While the small numbers involved preclude statistical analysis it is notable that all four patients who were retarded but not overinclusive had their overinclusiveness increased by speeding their performance, while slowing the performance of those patients who were overinclusive but not retarded decreased their overinclusiveness.

The mean time taken by the five overinclusive patients to complete the card-sorting test under untimed conditions was less than one-half that

Table 2. Mean scores obtained on the card-sorting test under untimed and paced conditions

	Overinclusive group (n = 10)			Non-overinclusive group (n = 10)		
	Trial 1 (untimed)	Trial 2 (slowed)	t corr. (T1-T2)	Trial 1 (untimed)	Trial 2 (speeded)	t corr. (T1-T2)
Correct sortings						
Mean	20.9	32.2	7.06	39.0	34.4	2.51
S.D.	3.5	3.7	$P < 0.01$	3.6	8.7	$P < 0.05$
Associative errors						
Mean	22.9	11.8	6.93	5.0	9.7	2.46
S.D.	3.8	3.9	$P < 0.01$	3.2	8.7	$P < 0.05$
Irrelevant sortings						
Mean	1.2	1.0	0.69	1.0	0.9	0.32
S.D.	0.8	1.05	n.s.	0.8	0.7	n.s.
Time taken (sec.)						
Mean	426.6	589.5	2.11	540.5	346.5	2.00
S.D.	167.2	178.5	$P < 0.02$	270.1	144.9	$P < 0.05$

Despite the fact that overinclusion and retardation were not negatively correlated in the total group, predictions made from the theory were largely upheld, suggesting that in a group of schizophrenics in whom the predicted relationship obtained the effect of varying the pressure to respond may be even more marked. In order to examine this *post hoc* hypothesis consideration was given to those five patients who were over-

of the four non-overinclusive subjects (307 and 708 sec. respectively), suggesting that overinclusive subjects respond at a rate in excess of what would be optimum if they were to minimize their overinclusiveness. Under the differential conditions of the second trial the two groups did not differ in their mean overinclusion score, if anything the initially 'non-overinclusive' subjects were the more overinclusive.

Table 3. *Associative error scores obtained on the card-sorting test by overinclusive and retarded schizophrenics under untimed and paced conditions*

Non-overinclusive retarded schizophrenics			Overinclusive, non-retarded schizophrenics		
Patient	T1 (untimed)	T2 (speeded)	Patient	T1 (untimed)	T2 (slowed)
JHI	1	4	SO	29	11
PC	6	7	JC	20	7
LA	9	17	GP	22	13
MF	10	22	VB	28	16
			JH	17	12

DISCUSSION

While the predicted negative relationship between overinclusion and retardation in schizophrenia was not found to hold for the total group, it nevertheless proved possible to manipulate the degree of overinclusion shown by schizophrenics by varying the rate at which they responded. If consideration is given only to those patients who satisfy the original assumption regarding overinclusion and retardation the predictions made from the theory are met in every case. Clearly, however, the evidence of the present investigation alone is insufficient to confirm the theory proposed here. The view that chronicity is attended by an increase in psychomotor retardation and a decrease in overinclusiveness needs to be tested by a longitudinal investigation in which the same patients are seen at different stages of their illness. An inverse relationship between speed and accuracy has been demonstrated in a large number of tasks. It is conceivable that sorting by association is quicker than sorting by conceptual class and that speed and conceptualization can be traded. If this is the case what is being regarded as indicative of overinclusiveness in the present instance (i.e. associative errors) may only reflect this general relationship between the speed of response and accuracy. To establish that it is overinclusiveness which is being manifested would require that some other test of overinclusiveness, known to be independent of rate of response, correlate signifi-

cantly with performance on the card-sorting test under untimed conditions. In contradiction to the view that it is only the relationship between speed and accuracy which is being assessed in the present situation is the unexpected positive correlation, though insignificant, found between the number of associative errors made on the card-sorting test and the measure of retardation.

The failure to show that overinclusion and retardation were negatively related in the total group, while not inconsistent with previous evidence, may be due to the particular measures employed since different tests of overinclusion and retardation have been found to have only marginal correlations with one another (Hawks, 1964; Watson, 1967; Phillips *et al.* 1965). Price (1970) has argued that 'overinclusion' has itself become an overinclusive concept having a number of different connotations and assessed by tests having low intercorrelations. In replicating the present study attention would need to be given not only to the selection of subjects but the use of more than one test of overinclusion and retardation.

Rather than base the decision to speed or slow an individual patient on the divergence of his scores on the overinclusion and retardation tests from group norms it would be preferable to alternatively slow and speed each individual and observe the effect on his overinclusion test performance. Such a strategy would accommodate the possibility that the relationship between overinclusion

and retardation may vary according to the particular stage of the schizophrenic process.

The view that psychomotor retardation results from an attempt to cope with information overload need not only be applicable to schizophrenia.

If one accepts the view that the organism has a limited capacity to deal with incoming information as Broadbent (1958) and others have suggested, and that information can be received from both the external and internal environment then it is conceivable that in any condition in which the potency of internal sources of stimulation is increased, such as occurs in psychotic states, there is a reciprocal decline in the organism's ability to cope with information received from the external environment. Such a formulation suggests that in the acute stage of any psychotic illness there will be a heightened awareness of normally disregarded subjective and somatic experience which interferes with the organism's ability to process information received from the external environment. Such a heightened awareness has been reported in acute schizophrenics (Chapman, 1966). Chapman & McGhie (1963) have pointed to the therapeutic implications of this model in proposing that schizophrenics communicate better in a setting in which extraneous stimuli have been excluded and the speed of conversation slowed.

If, as is widely accepted, people normally cope with information overload by slowing the rate at which they respond it is hardly surprising that psychotics should adopt a similar strategy. A testable prediction which follows from this formulation is that retardation in depressive patients should vary according to the severity of their depressive mood, with an improvement in mood being associated with a lessening of their degree of retardation.

SUMMARY

The view is expressed that overinclusive thinking and retardation in schizophrenia are both manifestations of the same basic attention defect.

It is hypothesized that the condition of information overload which results from the schizophrenic's inability to screen out extraneous sources of stimulation is adjusted to in some cases by slowing the rate at which information is processed. Such cases show retardation but do not appear overinclusive. Schizophrenics who do not learn to retard the rate at which they process information will on the other hand appear overinclusive. It should follow then that experimentally increasing the rate of response of retarded schizophrenics should cause them to become overinclusive, whilst slowing the rate of response of overinclusive schizophrenics should diminish their overinclusiveness.

A group of 20 schizophrenics were first given the Chapman Card Sorting Test and the Babcock Digit Substitution Test under standard conditions and classified as overinclusive or non-overinclusive according to the number of associative errors they made on the card-sorting task. According to whether they were overinclusive or non-overinclusive subjects were then instructed either to decrease or increase their rate of response respectively when retested on the card-sorting test. As predicted the overinclusive schizophrenics were significantly less overinclusive and the non-overinclusive schizophrenics significantly more overinclusive on the second trial.

Contrary to prediction overinclusion and retardation as measured by the Babcock Substitution Test were not negatively correlated. However, a separate analysis performed on those subjects in whom this negative relationship prevailed showed that in every case the differential instructions produced the predicted effect.

It is proposed that in any psychotic illness in which the potency of internal sources of stimulation is increased there will be a reciprocal decline in the organism's ability to cope with stimulation from the external environment, which in some cases may be adjusted to by slowing the rate of response.

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APPENDIX

Individual data on all subjects

Patient	Diagnosis	IQ (Mill Hill)	Educa- tion (years)	Age (years)	Hospital- ization (years)	Babcock digit- substi- tution test (sec.)	Card-sorting test			
							Associative error scores		Time (sec.)	
							T 1	T 2	T 1	T 2
JHI	Chr. Para.	94	14	37	18	140	1	4	576	320
PC	Chr. Simp.	92	10	38	7	187	6	7	454	300
LA	Chr. Para.	92	9	40	4	182	9	17	511	388
MF	Chr. Para.	82	11	45	12	291	10	22	1292	738
FE	Chr. Para.	82	8	38	14	168	21	14	648	721
HB	Chr. Para.	82	8	38	14	168	21	14	648	721
ES	Chr. Para.	94	15	49	12	88	4	5	434	328
SO	Chr. Para.	100	9	37	14	94	8	26	448	241
JC	Ac. Para.	110	16	43	0.2	65	29	11	288	531
GP	Chr. Hebe.	110	11	38	0.5	100	20	7	238	381
VB	Ac. Para.	110	11	22	0.3	100	22	13	266	377
JH	Chr. Cata/Para.	98	10	28	0.4	95	28	16	502	905
SB	Chr. Cata.	96	10	20	0.1	99	17	12	241	395
SG	Ac. Para.	118	12	18	0.1	68	2	3	375	265
SC	Ac. Para.	120	15	21	0.1	85	1	2	485	289
FG	Ac. Para.	106	12	22	0.2	91	5	7	429	348
MW	Chr. Para.	109	11	37	0.3	108	4	4	401	248
EB	Chr. Para.	83	10	32	0.3	265	20	17	712	729
CS	Chr. Para.	100	11	22	0.4	125	24	9	466	562
HA	Chr. Cata/Para.	106	11	17	0.5	204	22	5	495	697
	Chr. Para.	98	10	35	0.7	171	26	14	390	617

The reliability and utility of a clinical rating of personality

BY ALISTAIR E. PHILIP* AND LORNA CAY†

While studying a group of peptic ulcer patients Cay (1968) found that a retrospective rating of 'personality resources' correlated significantly with both the physical and psychiatric outcome of her cohort. This finding suggested that global ratings of personality resources could be useful if it were possible to ascertain the reliability and validity of such ratings.

Global terms are used freely by psychiatrists in describing their patients. For those following the psychobiological approach of Meyer, personality is 'the integrated activity of all the reaction-tendencies of the daily life of the individual...the person as he is known to his friends' (Henderson & Gillespie, 1956). In this approach the assessment of the patient as a whole is paramount, certain personalities being seen as being less adapted to meet stress than others. The avowedly non-Meyerian approach favoured by Mayer-Gross *et al.* (1960) makes similar use of global appraisals, patients being considered of 'good' or 'vulnerable' personalities. Both these influential textbooks stress the importance of detailed descriptions of character using everyday language. Mayer-Gross *et al.* stress the need for psychiatrists to employ some frame of reference in which their experience, both individual and collective, can be arrayed. In Scandinavia the work of Sjöbring (1958) and others has provided clinicians with a set of personality dimensions which can be used to describe patients. In Britain no similar systematic clinical scheme has been formulated; in consequence, each clinician has been forced to rely on his own skills. It is necessary to

translate such private skills into something more public before their worth can be assessed. One form of translation is to identify the concepts which underlie a clinician's assessments using one of the methods based on Kelly's theory of personal constructs (Kelly, 1955). Another is to relate the assessments to some other form of appraisal.

The study had three aims: (1) to ascertain the reliability of a clinician's global rating of 'goodness of personality resources', (2) to see how other constructs were related to such a global rating, (3) to ascertain the ways in which individuals rated on a global rating differ in respect of a number of personality dimensions.

METHOD

Seventy-six patients admitted to the Gastro-Intestinal Unit of the Western General Hospital, Edinburgh who had not had definitive treatment for their disease were examined by a psychiatrist (L. C.), who also administered a battery of psychological tests. From the interview data a clinical rating of goodness of personality resources was made using a five-point scale (definitely good, on balance good, uncertain, on balance poor, definitely poor). At their leisure the patients then completed the Hostility and Direction of Hostility Questionnaire, or HDHQ (Caine *et al.*, 1967) and the Sixteen Personality Factor Questionnaire, or 16PF (Cattell & Eber, 1965). Not all patients completed these tests. The HDHQ provides measures of an individual's intro-punitive and extrapunitive attitudes (Philip, 1969), while the 16 PF assesses personality in terms of 16 primary personality traits or factors. These factors correlate modestly with one another so that it is possible to reduce the 16 traits to a smaller number of broader but less exact secondary dimensions, two of which, Anxiety and Introversion-Extraversion, are included here. For both questionnaires, scores are presented on a standard 10-point scale (or sten scale) whose mean is set at

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5.5 sten. Scores of 5 and 6 are average, with stens from 4 to 1 and from 7 to 10 indicating increasing departure from the mean.

Some 3 months after all the patients had been

times, the trio of persons being different on each occasion. Twenty-eight constructs were elicited and these appear in Table 1 along with the given construct 'Has good personality resources'.

Table 1. *Constructs elicited from clinician*

Order of presentation for rating	Construct	Correlation with global rating
9	Has a stable personality	
8	Is immature	0.85
14	Is grossly inadequate	-0.83
10	Is able to cope	-0.81
6	Is in control of self	0.79
3	Has a well preserved personality	0.79
25	Cannot accept responsibilities	0.78
27	Is dependent	-0.78
24	Has a brittle personality	-0.77
28	Is a person I could get on well with	-0.72
18	Is a solid individual	0.71
11	Needs the support of others	0.68
17	Is too eager to succumb to illness	-0.63
16	Is a steady worker	-0.61
5	Is dissatisfied	0.60
23	Has struggled against illness	-0.60
13	Has given in to problems	0.56
26	Is a complainer	-0.55
2	Is miserable in spirits	-0.54
22	Has had a depressive reaction to illness	-0.48
21	Is afraid of social contacts	-0.48
20	Is tense	-0.47
4	Is keen on social life	0.40
19	Is perfectionistic	0.38
1	Is of limited intelligence	0.32
7	Has a stable family background	-0.27
12	Has lost support recently	0.26
15	Is ambitious	-0.24
		0.23

Significance levels for 74 d.f. are: $r_{0.05} = 0.23$; $r_{0.01} = 0.29$; $r_{0.001} = 0.37$.

interviewed and tested, the psychiatrist's constructs about them were elicited. The names of 20 patients drawn at random from the group were written on cards which were then well shuffled. The first three cards were presented to the psychiatrist, who was asked to say in what way two of the people were alike and differed from the third. This procedure was continued until the name of each person had been presented three

Each of the 76 patients was then rated on a seven-point scale for each construct and product-moment correlations were calculated between these constructs. Correlations between the previously rated scale of 'goodness of personality resources' and the constructs were also calculated. Finally the psychological test scores of patients given different ratings were compared using one-way analysis of variance.

RESULTS

When the scores on the construct 'Has good personality resources' were correlated with the original ratings of goodness of personality resources a correlation of 0.94 was obtained. This indicates that the clinician used the global concept in an exceptionally reliable way.

Table 2 presents the scores obtained by patients on the HDHQ and 16PF. As a group their scores do not depart from the normal range. When analysis of variance was carried out on the traits to see if there were differences between individuals falling in the five categories of global assessment, several significant differences were found. On the HDHQ both extrapuniteness ($F = 2.81$;

Table 2. *Psychological test scores of patients rated for personality resources*

16 PF High score description		Rated personality resources				Poor <i>n</i> = 7	All cases <i>n</i> = 68
		Good <i>n</i> = 14	<i>n</i> = 18	<i>n</i> = 14	<i>n</i> = 15		
A	Outgoing	5.4	6.1	5.1	5.5	5.6	5.5
B	Intelligent	6.9	6.9	6.9	7.1	5.6	6.8
C	Stable	5.5	4.9	5.2	4.3	2.7	4.7
E	Dominant	4.6	4.1	4.6	5.1	5.7	4.7
F	Enthusiastic	5.1	5.8	4.9	4.9	4.9	5.2
G	Conscientious	6.3	5.4	6.2	4.5	5.3	5.5
H	Venturesome	6.0	4.9	4.5	3.9	4.6	4.8
I	Sensitive	4.9	4.9	6.1	5.3	6.0	5.4
L	Suspecting	4.9	4.6	4.9	6.2	6.0	5.2
M	Self-absorbed	4.3	5.9	5.9	5.2	6.0	5.4
N	Sophisticated	5.9	5.6	5.9	6.2	4.9	5.8
O	Apprehensive	4.8	5.6	5.8	7.3	8.3	6.1
Q ₁	Radical	6.0	5.8	5.5	4.9	5.7	5.6
Q ₂	Self-sufficient	6.5	7.0	7.0	7.0	6.4	6.8
Q ₃	Self-controlled	5.8	6.4	5.9	5.7	4.6	5.8
Q ₄	Tense	4.1	4.4	5.4	6.8	6.6	5.3
Anxiety		4.3	5.5	5.4	7.0	7.9	5.7
Introversion-Extraversion		4.7	4.5	3.7	3.5	4.3	4.1
HDHQ		<i>n</i> = 17	<i>n</i> = 19	<i>n</i> = 14	<i>n</i> = 16	<i>n</i> = 7	<i>n</i> = 72
Extrapunitiveness		5.4	6.0	5.0	6.1	7.0	5.8
Intropunitiveness		4.0	4.9	4.1	6.3	6.6	5.0

The column of coefficients on the right of Table 1 shows the correlation which each construct had with the original rating of goodness of personality resources; the figures on the left refer to the order of presentation on the data schedule. All the constructs correlate significantly with the original rating of goodness of personality. The corrected multiple correlation of all constructs with the original rating is 0.91.

d.f. = 4, 67; $P < 0.05$) and intropunitiveness ($F = 4.08$, d.f. = 4, 67; $P < 0.01$) showed differences between the groups. Those rated as being of poor personality were the most extrapunitive and also the most intropunitive. On the intropunitive measure, but not on the extrapunitive, there is some evidence of a gradient linking decreasing amounts of personality resources with increased intropunitiveness. On the 16PF, second-order

Anxiety ($F = 17.66$; d.f. = 4, 63; $P < 0.001$) and three of the primary factors associated with it, namely H ($F = 3.70$; d.f. = 4, 63; $P < 0.01$), O ($F = 7.39$; d.f. = 4, 63; $P < 0.001$) and Q_4 ($F = 4.75$; d.f. = 4, 63; $P < 0.1$) show a similar gradient of scores. Those rated as having good personality resources are seen to be less anxious than average, more outgoing than the others, less apprehensive and less tense. At the other extreme those rated as being of poor personality resources are characterized by being very shy and restrained, rather tense and very apprehensive and troubled, the overall picture being of a group with a great deal of emotional upset. Factor G ($F = 2.85$; d.f. = 4, 63; $P < 0.05$) shows an overall significant difference but the scores do not differ in any apparently meaningful way.

Those rated as having definitely good personality and those rated 'uncertain' obtain scores which indicate that they are more conscientious and persevering than those who on balance have good resources and those who have definitely poor resources; these in turn are more conscientious than those patients who on balance have poor resources.

DISCUSSION

The correlation between the two ratings of goodness of personality resources is exceedingly high, especially when it is considered that an interval of several months separated the two ratings. Had it occurred in isolation then such a correlation could have been dismissed as being due to some artifact. The high correlations which the other constructs have with the original rating suggest that the results are not due to artifact; this clinician at least has a number of constructs which are themselves fairly global in their description of persons and which correlate well with the original global assessment. The procedure of eliciting constructs has produced terms which have a fairly wide range of meaning. Those terms, when taken together, relate well to the global appraisal, but because of their own

wide range of meaning they add less than might be expected to a knowledge of what is implied by a rating of good resources.

In the present case it is clear that patients classified according to a clinical appraisal of their personalities were being classified in a meaningful way. The questionnaire results point to apprehensiveness, tenseness, intro-punitiveness and some degree of social withdrawal as being dimensions along which they varied. The 16PF second-order factor of Anxiety is the dimension which is the best single discriminating measure between the rating categories. Cattell (1964) describes the anxious person in the following terms; on the one hand is shown irritability, suspicion of others and tenseness, and on the other hand lack of confidence, dependency and a sense of guilt and worthlessness. Anxiety in Cattell's system is considered to be a disorganizing force or symptom of disorganization rather than a drive or motivating force. High scores have been found in alcoholics (Fuller, 1966) and attempted suicides (Philip & McCulloch, 1968; Philip, 1970) as well as in a wide range of psychiatric disorders with less social pathology than the former groups (IPAT, 1967). The general quality of this factor is emotional upset in its widest sense; little wonder that it is this dimension which differentiates persons categorized according to an equally wide clinical dimension.

The global rating studied here has been shown to be a reliable and, in view of its relation to the psychological test data presented, a fairly valid measure. High anxiety scores on Cattell's tests tend to pick out individuals who are disorganized in their lives and who, whatever their physical or psychiatric complaint, have unfavourable prognoses. Clinical appraisal by scales such as that examined here can be used to identify vulnerable individuals provided the rating and its underlying constructs can be shown to be reliable and valid. These qualities depend on the acquisition and appropriate use of clinical skills. As has been indicated earlier, textbooks of psychiatry lay

SUMMARY

considerable stress on skills of this sort, but in practice their acquisition is too often left to chance. Many skilled clinicians find it hard to pass on their skills to their juniors in any way other than by example; the method suggested in this study is one which would allow some of these skills to be made more explicit.

Rutter & Brown (1966) amongst others have indicated that interviewers can rate a wide range of behaviours provided the criteria for making such ratings are spelled out and interviewers agree or are trained to concur on the evaluation of individual behaviours. Lest the present paper be construed as encouraging clinicians to indulge their subjective impressions it is appropriate to repeat the cautionary remarks already made. Clinical ratings are most useful when their underlying conceptual process can be made public. This paper has presented one method of achieving this desirable end.

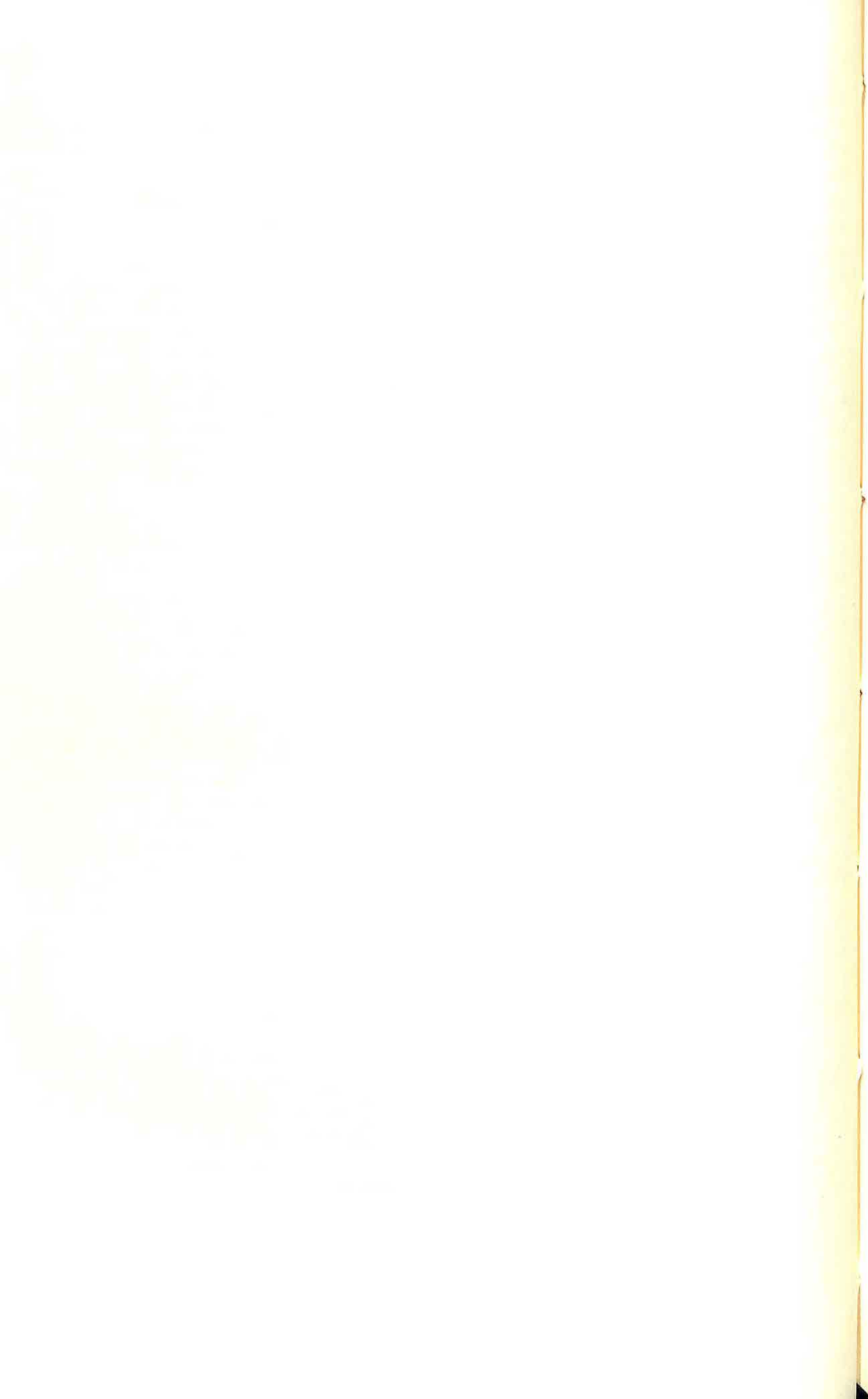
A clinician's use of a global rating of personality has been investigated. The reliability of the rating has proved to be very high and an examination of the clinician's personal construct system has shown that the rating is the most global of a number of evaluative constructs. Patients rated on this global concept differ on a number of personality measures. On the 16 PF there are differences on second-order anxiety as well as on several of that factor's primary constituents. On the Hostility and Direction of Hostility Questionnaire those rated of poor personality are more intro-punitive and also more extrapunitive than the others. Provided that some knowledge of their reliability and validity is available, it is clear that clinical appraisals of personality are useful in a variety of situations.

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Obituary

ROBERT L. MOODY

Dr Robert Moody died suddenly and unexpectedly in his 62nd year on 26 August 1970, while on holiday in his cottage at Devon.

Robert Moody received his medical training at St Thomas's Hospital, taking his M.B., B.S. and his conjoint in 1935, and his D.P.M. in 1938. From the very beginning his interest lay in psychological medicine, and in particular in child psychiatry. Among other posts he held the post of registrar in psychological medicine and in child psychiatry at Guy's Hospital, and he was clinical director of the Child Guidance Training Centre. He also was a Sir Alfred Fripp memorial research fellow in child psychiatry at Guy's. During the war years he worked as a psychiatrist to the Emergency Medical Service at Woodside Hospital. In 1948 he was appointed child psychiatrist at St George's Hospital, Hyde Park Corner. He also worked in the hospital's psychiatric department at the Victoria Hospital for Children, Tite Street. As physician-in-charge of the department of child psychiatry (which had always been an independent department) Robert Moody tried to maintain the high standard set by his predecessor, Emanuel Miller. He encouraged an even closer liaison with the paediatric unit: joint case conferences were regularly held and generations of medical students learnt the value of an integrated approach to family and individual problems. Side by side with his work at his department he played an active part in the affairs of the Association of Child Psychotherapists (non-medical) as a member of their Medical Advisory and Training Council, and as a chairman of their Selection Committee.

When in 1945 the London Society of Analytical Psychology was founded, Robert Moody was one of its foundation members and played a prominent part in the formative

years of the society. After acting as its first honorary secretary he was elected chairman of the society in 1948 and again in 1950. In addition he was for three years chairman of the professional committee of the society and an assistant editor of the *Journal of Analytical Psychology*. When the time for the creation of an international organization had arrived, Robert Moody was instrumental in its foundation, and in 1955 became its first president. In 1958 he was re-elected for a second three-year term, but had to resign in the following year on account of illness.

Robert Moody was a gentle and quiet person, but a great fighter when it came to issues about which he felt strongly. Thus he put tremendous energy into the establishment of his department and its progress. The amount of work he went through was astonishing, and his dedication to his office undoubtedly contributed to his early death. He was an inspiring teacher, and his particular interest in the connexion between child psychiatry and paediatrics attracted many paediatric students. They benefited greatly from his experience as a clinician, coupled with his deep understanding derived from his analytical work.

As chairman of committees he showed a unique sense of proportion and fairness, and his sense of humour helped to save many a meeting from boredom and discord. He was a deeply sensitive, kind, and understanding person. His interests included music—he was an accomplished amateur pianist—and painting. He was looking forward to the days when he could devote more time to these pursuits and to his garden at his Devon cottage. His death will be felt as a great loss by friends and colleagues. He leaves a wife, and a daughter by a former marriage.

G. A.

Book Review

Put Away: A Sociological Study of Institutions for the Mentally Retarded. By PAULINE MORRIS. London: Routledge & Kegan Paul. 1969. Pp. 355. 60s.

This book reports a job well done. At the invitation of the National Society for Mentally Handicapped Children and with their financial support, the physical setting, the kind of patients, the staff and the community life of institutions for the mentally subnormal were examined. In addition, the study concerned itself with the explicit or implicit policy of these organizations. It tells, in nearly every respect, a sad tale.

The study looks methodologically sound, the sample is nearly 50 per cent, cooperation was high and the text is clear. Typically from this publishing house, the well-made book is splendid value.

Naturally, the findings are that we are wanting in almost every particular. The facilities are outdated, inadequate, overcrowded, dull and smelly. The staff are insufficient, ill-trained, bored and frustrated, and their systems of communication and administration functions tend only to accentuate these deficiencies. All specialist departments are understaffed, misunderstood and very poorly integrated into the therapeutic scheme of things. Life and relationships in the community leave much to be desired from the meetings of hospital management committees down to patients' parties. Each area of discourse is examined and reported without passion, which, in the circum-

stances, deserves particular commendation. The report is made even more telling by its insistence on sticking to sociology and never trespassing on to 'medicine'. There is quite enough to be learned in one lesson from comparing, as Professor Townsend states in his introduction, what is actually happening with what is *said* to be happening and what it is believed *ought* to be happening.

Yet, possibly because of its self-control, it has a somewhat disconcerting naivety. A reader might be confused between what are the particular evils of these organizations, as seen by a sociologist, and the evils sociologists might see as inherent in any organization. What is ugly is a matter of taste, what is outdated a matter of definition, what is vile a matter of custom. What would constitute training depends upon what is to be trained for, and this, in the particular of the care of the mentally subnormal, is extremely clear. In effect the deficiencies described here in our care of the mentally subnormal are capable of considerable generalization and their resolution is far less dependent upon the skills and personality resources of the staff concerned than it is upon the general structure of the social system. If society moves towards valuing and caring for all men irrespective of their ability to contribute material benefit to that society, then this book describes ephemera. If not, then the book will become a classic description of a certain state of affairs.

DAVID C. TAYLOR

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Hysterical psychosis: psychopathological aspects

By V. SIOMOPOULOS*

In 1964 Hollender & Hirsch attempted to reinstitute the old term 'hysterical psychosis' as applying to a clinical entity encountered most commonly in persons with hysterical personalities and characterized by psychotic symptomatology of sudden onset and short duration. As described by these authors, the clinical picture of hysterical psychosis develops after a period of increasing stress, includes delusions, hallucinations, depersonalization and grossly unusual behaviour, and seldom lasts longer than one to three weeks. In the same year Mallett & Gold (1964) discussed 13 patients, all women, with an illness at some stage of which the diagnosis of schizophrenia was made on the basis of unsuccessful treatment as well as the presence of emotional emptiness, bizarre depersonalization phenomena, paranoid thinking and dramatic visual hallucinations, sometimes accompanied by auditory ones. All patients described by these authors displayed what their therapists considered to be characteristically hysterical personality traits, i.e. egocentricity, psychosexual immaturity, lability of mood and shallowness of emotional contact. In every case, admission to the hospital followed an acute episode of violent or negativistic and symbolic behaviour or a suicidal attempt. Five of these patients committed suicide during hospitalization or after discharge. The illness was ultimately regarded by these authors as a pseudoschizophrenic hysterical syndrome.

Hirsch & Hollender (1969) suggested that the clinical picture of hysterical psychosis might present in three patterns: (1) as socio-cultural sanctioned behaviour, i.e. behaviour determined by the prevailing belief system of

a given culture, e.g. as it is encountered among the natives of New Guinea; (2) as simulation of psychotic behaviour; (3) as true psychosis with temporary ego disruption. According to these authors, the borderline between the third type of hysterical psychosis and schizophrenia is fuzzy and differential diagnosis between the two disorders can be made 'in a general way but not with unfailing precision'.

Apparently, the frequent confusion of hysterical psychosis with schizophrenia originates from the presence of delusions and hallucinations in both illnesses. This paper discusses certain aspects of psychopathology of the delusional-hallucinatory experiences of hysterical psychosis, which appear to differentiate this illness from schizophrenia.

Delusions in general are defined as 'incorrigible false beliefs that are not shared or sanctioned by a group' (Redlich & Freedman, 1966). This definition finds an unquestionable application in the delusional ideas of schizophrenic patients. Can the delusions of hysterical psychosis be described as incorrigible false beliefs? Bleuler (1924) wondered how far hysterical delusional formation can go, but he left the question essentially unanswered. Angyal (1965) used the term 'borderline hysteria' to describe patients with hysterical personality traits who are often acting out delusion-like fantasies and are considered psychotic, but they are in fairly good contact with reality. According to Angyal, the delusion-like ideas of these patients differ from delusions proper 'by not having quite the same degree of reality value for the patient'. Fenichel (1945) had already remarked, under the heading 'borderline states', that

often ideas with a typical delusional content are developed while the patient is still capable of full reality testing; he does not believe in the ideas and calls them 'crazy'.

* Research Unit on Schizophrenia, Illinois State Psychiatric Institute, and University of Illinois College of Medicine, Chicago, Illinois.

Yet he made no connexion of his finding with hysterical psychosis or hysterical personality. We have observed that the delusional ideas expressed by patients with the clinical picture of true hysterical psychosis, as described by Hollender & Hirsch, though typically delusional in their content, i.e. false, do not have the characteristic of incorrigibility, an essential feature of the delusion proper. Almost invariably, these patients communicate to the interviewer, directly or indirectly, that they do not really believe in their delusional ideas.

The nature of hallucinations of hysterical psychosis is another aspect of this illness that is discussed in this paper. In contrast to schizophrenic patients, who give vivid verbatim accounts of their auditory hallucinations, hysterical psychotic patients describe their hallucinatory experiences vaguely, make contradictory statements, and look embarrassed when they are asked to reproduce the exact wording of their 'voices'. The vagueness of their descriptions is reminiscent of the descriptive vagueness of hysterical pains. Freud (1893-95, p. 136) had been struck 'by the indefiniteness of all the descriptions of the character of the pains' of Elisabeth von R. Szasz (1961) attempted to explain this vagueness of hysterical patients in the framework of his theory that hysteria is a mode of communication in a non-discursive, pictorial body language. Thus, he proposed, the hysterical patient finds it difficult to express his bodily feelings, because 'non-discursive languages do not lend themselves to translation into other idioms, least of all into discursive forms'. However, though pain might be part of a non-discursive, pictorial symbol system, auditory hallucinations certainly are not. We contend that when these patients talk about their 'voices' or 'visions' they communicate thought contents rather than specific perceptual occurrences accessible to recall. In contrast to schizophrenic hallucinations, which represent perceptualization of thought contents, the hallucinations of hysterical psychosis are thought contents which are communicated as

perceptual experiences without having been previously perceptualized.

The following two clinical examples illustrating the above observations have been selected from patients admitted to the Illinois State Psychiatric Institute during the last five years.

CLINICAL EXAMPLES

Case 1. On Valentine's day, about four weeks before admission to the hospital, a 33-year-old woman communicated to her husband that God was talking to her and guiding her actions. When her husband pointed out to her that this was 'nonsense', she angrily replied that God was not only advising her, but also had told her that she was spiritually married to a man in the neighbourhood, a 23-year-old medical student. For the next few weeks the patient neglected the care of her children as well as the usual housework and appeared extremely irritable. On admission, she stated that there was nothing wrong with her, but she came to the hospital because God told her so. She was admitted with the diagnosis of schizophrenia, paranoid type.

The patient was born and raised in a small town of Illinois. When she was an infant, her father had a 'nervous breakdown' from which he never recovered, and at the time of the patient's admission to the hospital he was an in-patient at a state mental hospital with the diagnosis of schizophrenia, paranoid type. When the patient was 4 years old, her mother divorced her husband and remarried. The patient felt quite rejected by both mother and stepfather throughout the period she lived with them. She met her husband when she was 18 and married him about 2 years later.

The patient is the mother of three children of ages ranging from 3 to 11. About 3 years before the present admission, soon after the youngest child was born, the patient developed dizziness, headaches and palpitations. She was frightened to be left alone and insisted that her husband stay with her all the time. She had frequent crying spells, complaining that her husband did not love her. This precipitated a brief hospitalization with the diagnosis of depressive reaction in a hysterical personality. A long period of friction between the patient and her husband followed. A few weeks before her present hospitalization, the patient became verbally and physically abusive toward her husband.

In the hospital, the course of her illness was marked by sudden dramatic changes. On one day she would talk for hours with almost everyone on the unit about her communication with God and she might send her therapist numerous incoherent letters referring to the cure of leukaemia, cancer and other diseases. On the next day she would refuse to talk about God; instead, she would discuss in a realistic manner the problems existing between her and her husband, the fact that he was working on a night shift and that she was feeling terribly lonely at home. This off-and-on psychotic and non-psychotic behaviour continued for several weeks. When, on several occasions, she was asked to give a verbatim account of her communication with God, she looked embarrassed and limited herself to descriptions of thoughts rather than auditory experiences. Characteristically, her replies started always with the phrase, 'God told me that...'. Psychological testing during this time showed that the present decompensation and loss of reality testing were not as severe as the clinical picture might have suggested. Her premorbid personality structure was considered to be of the hysterical type.

About 5-6 weeks after admission the patient appeared symptom-free in a stable manner and a few weeks later she was discharged as improved.

Case 2. A 21-year-old single woman was admitted to the hospital with the complaints that for the last few weeks before her admission she was hearing 'voices' commanding her to commit suicide and also that two men in the neighbourhood, father and son, were trying to detect her thoughts and control her mind with tiny microphones which they had placed in her diet pills. These microphones, according to the patient, had now spread all over her body. She was admitted to the hospital with the diagnosis of schizophrenia, paranoid type.

The patient was born into a lower class Jewish family, third-generation immigrants from an eastern European country. She has a twin sister with no history of psychiatric treatment and another sister, 27 years old, who has been hospitalized off and on for the last 4 years for repeated attacks of anxiety with bizarre depersonalization phenomena and an underlying personality structure variously diagnosed at different times as infantile personality, hysterical personality and borderline personality.

The patient and her older sister had little inter-

est in school or work; they did not graduate from high school and worked only for short periods of time. All three sisters have been very attached to their mother and each other and they often used physical or emotional complaints to elicit attention and love from her and each other. On the other hand, their mother frequently confided in them her grievances against her husband, accusing him of emotional coldness and rude behaviour. Frequently, out of resentment toward her husband, she refused to have sexual relations with him. The children could often hear their father at night insisting angrily that he have sexual intercourse with their mother.

The patient and her sisters dated frequently, but they 'never went as far as intercourse', and they are proud that they have retained their virginity so far. A few months before the patient became sick, a minority family arrived in the neighbourhood, and this stirred up a lot of anxiety and fears in the family of the patient. The patient especially became very embarrassed when, on several occasions, the son of the newly arrived family attempted to kiss her in an alley. It was this man and his father that the patient thought, later on, were trying to control her mind with tiny microphones.

On admission and throughout her hospitalization the patient was well dressed, clean and wore heavy make-up. Her speech was free-flowing and her associations were coherent and relevant. When she was asked to elaborate on her idea that she was carrying microphones in her body, she replied in a most contradictory manner. She stated that she knew that this idea was 'crazy', and that she did not really believe in what she was saying; yet, she also stated, with a smile on her face, as if she was finding the situation enjoyable or funny, that she 'believed in this, anyway'. She maintained this attitude of belief and non-belief in this idea until a few days after her admission, when she completely stopped talking about it. Her accounts of the 'voices' were also conflicting. Once she said that the 'voices' were coming from the microphones, next that they were not voices but just noises, then that they were voices telling her to kill herself, another time that they were not voices but just her own thoughts. On every occasion she talked about her 'voices' she was unable to give a verbatim account of them.

On the ward, she appeared childish, demanding and manipulative. Asking privileges and favours, provoking people and threatening suicide

became her only way of relating to staff as well as to other patients. This led her often to extreme nonsensical situations. Once, for example, about half an hour after she was refused a favour by the staff, she made known to everyone on the ward that she had made up her mind to kill herself that day. On several occasions, she inflicted superficial scratches on her arms, and once while on home visit she took an overdose of sleeping pills.

Though the acute clinical picture of this patient subsided a few days after her admission to the hospital, her severe characterological difficulties and the always present suicidal risk made it necessary to prolong her hospitalization to 5-6 months.

DISCUSSION

Shapiro (1965) and Kuiper (1967) have pointed out that the hysterical person quite often gives the impression that he does not really mean what he expresses. Shapiro (1965) has shown how easily the hysterical person is 'carried away' by his own histrionics, identifications with romantic figures, characters, heroic or not, that for some private reason are appealing to him. Paradoxical though it may be, it is not surprising that the hysterical psychotic appears not to believe in his delusional ideas. Hysterical psychosis might be seen as an exaggeration of certain aspects of the usual mode of cognitive and emotional functioning of the hysterical person. Angyal (1965) wrote referring to the state he called *borderline hysteria*:

The patient now embraces the hysterical mode of living with abandon. The hysterical forms of expression are cultivated and cherished, the resources of imagination are mobilized and recklessly used to form and uphold a vicarious pseudoexistence in an almost delusional fashion.

The hysterical person appears to carry into adulthood the child's unlimited capacity for fantasy life. Similarly, the hysterical psychotic appears to entertain certain ideas, wishes and fears in a manner closely resembling play activity of children. In children's play ordinary reality is transformed into a fantastical,

private, make-believe world, yet with full awareness by the child of the make-believe character of it. It is common knowledge that children are able to make the distinction between the real and the imaginary, yet they enjoy the subjective reality of their play and become rather annoyed when an adult attempts to point out the unreality of their activities.

The purpose of play, according to Erikson (1950), is 'to hallucinate ego mastery and yet also to practice it in an intermediate reality between fantasy and actuality'. In Piaget's (1962) words, play enables the child to master reality freely without a simultaneous forced accommodation to it. We propose that hysterical psychosis represents regression to the specific form of thought activity involved in children's play for the purpose and economy of mastering difficult life situations in a way that proved satisfactory in the past. A little child may transform pills or candies or any little object into tiny microphones in order to master the complicated technical world of adults. By transforming her diet pills into tiny microphones, our patient masters the threatening sexual advances of her neighbour and her fears of being seduced. Now, the philandering neighbour appears attempting to conquer her mind, not her body. Yet she is fully cognizant of the non-factual, make-believe character of this magical transformation. God advises the first patient we presented, just as an 'imaginary friend' guides the little child through the complexities of his little world. Apparently, the content of this play-thought activity is dynamically determined by the absence of father and the longing of the patient for love in the first case, the fear of sexual relations in the second case.

A basic difference between the formal thought mechanisms of schizophrenia and those present in hysterical psychosis is now evident. Hysterical psychosis is regressive behaviour containing elements of the thought activity involved in children's play. Schizophrenia involves regression to prelogical forms of thinking - the type of thinking that Freud

called primary process thinking; von Domarus, paralogic thinking; Arieti, paleologic thinking – which, though present in young children, are definitely, as Piaget has shown, not operating in play. In play and hysterical psychosis, fantasy diffuses into reality. The two states, acted-out fantasy and reality, exist side by side functioning in their own right and obeying their own rules of discourse. Breuer (1893–95, p. 45) wrote in reference to the hysterical illness of Anna O.:

Throughout the entire illness her two states of consciousness persisted side by side: the primary one in which she was quite normal psychically, and the secondary one which may well be likened to a dream in view of its wealth of imaginative products and hallucinations, its large gaps of memory and the lack of inhibition and control in its association. . . . The fact that the patient's mental condition was entirely dependent on the intrusion of this secondary state into the normal one seems to throw considerable light on at least one class of hysterical psychosis.

Elsewhere, he remarked, jointly with Freud (1893–95, p. 12), that 'the splitting of consciousness, which is so striking in the well-known classical cases under the form of "double conscience", is present to a rudimentary degree in every hysteria'. We suggest that the delusional ideas of hysterical psychosis constitute a microscopic picture in the area of thought processes of the massive splitting of consciousness that is identified, usually as a variant of conversion hysteria, as personality dissociation. We also suggest that a similar dissociative thought pattern is present in the hallucinations of hysterical psychosis.

McKegney (1967) proposed that the auditory hallucinations of hysterical persons might represent conversion reaction. According to this thesis, the 'leap' here is not from mind to body, as in classical hysteria, but from one psychic element to another. This view appears to assume that the hysterical patients who talk about hearing 'voices' do experience these 'voices' as sensory experiences. On the other hand, adopting the view that classical hysteri-

cal symptoms represent a form of body communication, one would assume that the functional equivalent of the body communication of hysterical paralysis is not the experience of 'voices', but the verbal communication of 'voices'. We contend that the label 'voices' used by these patients does not correspond to a recollection of the sensory experience it purports to describe, being merely a linguistic shift from the frame of reference of thought content to that of sensory experience. The profuse imagery of the hysterical person lends itself to this linguistic dissociation more easily when it comes to descriptions of visual hallucinations. Bleuler (1924) wrote, referring to hysteria: 'Even without the actual twilight states ideas can sometimes become so vivid that they are taken as hallucinations; it mostly involves visual disturbances.' Bleuler does not state clearly how the transition from ideas to visual hallucinations takes place, yet one is left with the impression that he does not mean that this process involves actual perceptualization of thought contents.

Apparently, the shifting of hysterical psychotic patients from one frame of reference to another becomes dynamically possible by several conscious or unconscious motives: the need of the patient to master her fears and communicate freely her fantasies, and also her wish to assume temporarily the dependent role of a sick person guaranteed by her 'hearing voices' or 'seeing visions'.

SUMMARY

Hysterical psychosis represents regression to the specific form of thought activity involved in children's play. Reality testing in hysterical psychosis is not impaired, yet fantasy diffuses into reality. The two states, acted-out fantasy and reality, exist side by side, functioning in their own right and obeying their own rules of discourse. Play and the delusional ideas of hysterical psychosis constitute a microscopic picture in the area of thought processes of the massive splitting of consciousness that is identified, usually as a variant of conversion hysteria, as personality

dissociation. Descriptions of auditory or visual hallucinations by hysterical psychotic patients represent not perceptualization of thought con-

tents, but a linguistic shift from the frame of reference of thought content to that of sensory experience.

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Aspects of the object relationships and developing skills of a 'mechanical boy'

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In this paper we will examine a schizophrenic youngster's creation and use of a series of machines while in treatment. We refer to our patient as a 'mechanical boy', after one of Bettelheim's (1959) patients, Joey. Joey believed that he himself was a machine and, more remarkably, he created this impression in others. Bettelheim reported that when Joey performed actions which were intrinsically human they always appeared to be started and executed by a machine. Our patient, Jim, did not verbally report that he was a machine, but at times he did relate how he 'merged' with machines. And on occasion he would give the impression of being a machine; when taken to a new room he turned his gaze to different areas and blinked his eyes as if he were a camera taking snapshots.

As we present a series of machines used or constructed by our patient while in treatment, we will discover multiple meanings in them. We will especially examine his unique way of dealing with tensions arising from his object relationships through the use of machines. The processes of introjection, projection and identification which took place in this connexion will be given special attention.

A REVIEW OF THE LITERATURE CONCERNING MAN'S PSYCHOLOGICAL CONNEXION WITH HIS MACHINES

There is a story about Albert the Great, who lived during the advent of machine technology.

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Wilhelmsen & Bret (1969), respectively a professor of philosophy and politics, and a teacher, write that, when confronted with a life-sized doll 'that could walk, a precursor of the robot, Albert smashed it with his staff. This spontaneous reaction - be it history or myth - bespeaks man's ancient fear that machines will one day render him obsolete'. The authors continue: 'the machine - by an internal logic utterly beyond any moral control insisted upon by the older philosophy - declares its independence of men, although... the declaration never truly becomes reality'. These writers might as well be describing the process of externalization or projection.

A brief review of the psychoanalytic literature concerning man's psychological link with his machine could start with Tausk's (1919) classic paper on the 'influencing machine'. Machines which influence the patient in a persecutory way in their delusions represent the projected symbol of his genitals and body. As the essay of Wilhelmsen & Bret suggested, a projected symbol in a sense 'declares its independence of man'. However, its psychological link to man never truly disappears, so 'the declaration never truly becomes reality'. Tausk described the hypochondriacal investment of organs, depersonalization and 'loss of ego boundaries' in the development of the 'influencing machine'. He also pointed out that dream interpretations could show that in dreams machines are symbolic representations of a patient's own genitals.

It is outside the scope of this brief review to dwell further on Tausk's classical contribution. The reader is referred to Roazen's (1969) recent book describing his versions of

events taking place in early psychoanalytic circles at the time the paper on the 'influencing machine' was written by Tausk. In spite of its 'now partly outdated conceptualizations' (Ekstein, 1966) Tausk's work contains the first comment that 'machines produced by man's ingenuity and created in the image of man are unconscious projections of man's bodily structure'. This notion was further developed by Kaufman (1932), and Sachs (1933) also confirmed Tausk's basic findings. Linn (1958), who reported his own case of the 'influencing machine' with completely classical characteristics, makes a point of stating that Kaufman's paper appeared in 1932 before Tausk's was available in English translation.

Elkisch & Mahler (1959) studied the infantile precursors of Tausk's 'influencing machine'. They stated that

The main difference between the adult and the child psychotic seems to be that in the adult the hallucinated (projected) outside machine influences the self, whereas, in the child psychotic, the influencing quality still manifestly pertains to his own self-representation and is then projected (secondarily) to the outer world.

On a clinical level the symptom of the 'influencing machine' on the one hand, and the process of 'merging' with an actual machine and going into total identification with it on the other, can be seen on the same line of the spectrum. The adult patient may go from one extreme of the spectrum to the other at different phases of his illness. In this ranging, his use of high-level projection mechanisms or a lower level of relatedness along the projective-introjective lines is critical. In the latter case there is no definite boundary between the self and the object representations. Therefore on a clinical level we see patients with delusions of 'influencing machines' in a classical sense, while we may see the opposite - patients who are 'mechanical boys'. Bettelheim's Joey was such a 'mechanical boy'. One patient briefly hospitalized at the University of Virginia Hos-

pital believed himself to be a machine, and felt that oil, not blood, ran through his veins. In the following paragraphs we will make reference to rather well-known patients in the psychoanalytic or psychiatric literature who had machines which either influenced them or were controlled by them, or which were partially or totally identified with them.

Rank (1949) described some young children with 'atypical development' who first identified themselves with inanimate objects (e.g. one patient, Henry, identified himself with a radio). Patients in the next stage identified themselves with animals before an identification with the mother or mother figure was possible. In the same year Bornstein (1949) reported the case of Frankie, a phobic patient, who had a 'remembering machine' which could be used in the reconstruction of the past and the present. Elkisch (1952) studied the relationship between the human figure and the machine in the spontaneous artwork of some boys. She suggested that the machine is an 'inanimate' organism. 'If we interpret its symbolism, the inanimate organism stands for the animate, the human organism; and the child's concern about the fitting together of parts refers to his own body, to his sexual curiosity'. Seventy-eight out of 150 drawings of one of her patients, Adison, dealt with machine's engines, mechanical parts, motors, and the like. She suggested that Adison's drawings of machines were related to sublimation in that the child expressed his curiosity, secret explosions, and sexual aggressive wishes in disguise. She continued 'the boy's identification with the machine... besides expressing aggression and self-defence also stood for making contact - contact all over the world'. Fox (1957) reported the case of an adult photographer who used the camera as an organ to control visual intake. Parker (1962) presented the detailed course of her psychoanalytically orientated psychotherapy with a 'disturbed' adolescent. Throughout her book she described the identification of David, her patient, with machines. David combated the unbearable feeling of loneliness by

identifying with non-living objects. 'This type of identification is a restitutional symptom which attempts to create a less threatening world-connection, independent of unreliable human beings'.

Bettelheim's Joey was first reported in 1959. Roazen (1969) writes about Tausk's influence on both Bettelheim and Federn. Ekstein (1966) described the case of a 5-year-old boy who had an 'influencing machine' like the one of Tausk's patient, Natalija A. Ekstein saw both the 'influencing machine' of his patient and that of Natalija A. as serving conflicting wishes towards symbiosis and individuation. Ekstein suggests that Tausk's patient, Natalija A., had the capacity to internalize the object; therefore she could create a completed machine which could function without the external physical objects and could derive its driving power from the force of her delusional fantasy. Ekstein's own patient, the psychotic child,

not having succeeded in internalizing the introjected image of the omnipotent father, could create only a precursor of the 'influencing machine'.

Ekstein also reported the case of Tommy, the Space Child, who had a 'time machine' and thus attempted to control the present and the future, not unlike Frankie, Bornstein's patient. Tommy resolved his essential problem of strengthening his ego 'through meaningful close relationships with optimum distance'. The defence mechanism of 'distancing' or, better, controlling the distance and also the 'intake' and 'contact all over the world' (Elkisch, 1952) will be described as one of the main features of our own Jim, who, according to our description of the clinical picture above, was closer to being a 'mechanical boy' than having a classical 'influencing machine'.

With the coming of artificial organs in medicine, the psychiatrist has to study the psychological aspects of the 'semi-artificial man' (Abram, 1969). Abram reported his findings of psychological aspects of patients' reactions to chronic haemodialysis at the

University of Virginia. He also reported a review of psychological aspects of patients' acceptance of artificial organs and chronic haemodialysis, and disturbances in their body images. 'Perhaps the first artificial organ associated with body image disturbance was the "iron lung".' There is a reference to Bill, a 7-year-old patient of Prugh & Tagiuri (1954), who incorporated his chest respirator as part of his body image.

CASE REPORT

Presenting symptoms

Jim, who was 16 years old at the time his treatment began, had had a diagnosis of schizophrenia, and intermittent contact with psychiatric resources for 6 years before his admission to our in-patient services. His symptoms included a history of school difficulties, although he finally managed to complete the eighth grade after several withdrawals for psychiatric treatment and private tutoring. He could not socialize with other youngsters, had become a management problem because of frequent raging outbursts, and seemed to have difficulty coordinating his left and right sides. When we first saw him, his main symptom was endless talk about his knowledge of electronic instruments, and an attempt to portray himself as a genius in electronic technology.

Psychiatric history

Identification. Jim is the younger of two sons of an upper middle-class Jewish family, with a brother 8 years older. His mother was ambivalent towards her children, and expressed resentment at being 'blackmailed by her sons'. His father is an executive and part owner of a small manufacturing company. He expressed helplessness about Jim's condition, and seemed to want to provide his son with material things in place of companionship.

During Jim's treatment he seldom referred to his elder brother, who at the age of 16 had also received psychiatric treatment after suffering for 2 years with a bleeding peptic ulcer. Later he underwent a subtotal gastrectomy. He had become 'rather well-adjusted' after finishing school and 2 years of psychiatric treatment, moved away from the family, and found employment.

Prenatal history. Jim's birth was the result of a planned pregnancy, and his mother claims to have had a normal course except for 'a bowel condition for 4 months'. Delivery was precipitous, in the car *en route* to the hospital. Severance took place in the delivery room; neither parent could remember anything about the child's condition at birth except that 'his fingers were blue'. Two weeks later the mother went into 'delayed reaction shock' which was not serious, and the possibility of a post-partum depression occurred to us.

Childhood. Jim's parents began their married life with the wife's family on a farm, but had lived by themselves as a family for about 6 years before Jim's admission to the hospital. Their first child was born 10 months after the marriage, and was 15 months old when the husband went overseas for 2 years. After his return from the service he and one of his wife's brothers ran the farm. They spent all their money remodelling it unprofitably. When the wife's parents moved to the farm, three families were living under one roof. Jim was born into this household, which was supported during this time mainly by the grandfather. When he was 2 years old his mother went to work, and his grandmother cared for him. There was considerable friction between the grandmother, the aunt and the mother.

From the beginning, Jim was a 'bad eater', and he was given a bottle until he was 2. According to his mother, he was 'afraid to walk'. Life became difficult for him when his mother went to work, and continued to be so for the next 7 or 8 years. His aunt had four children, one of whom was a boy she openly favoured over Jim. The aunt and grandmother bickered constantly over the former's treatment of Jim, sometimes actually sadistic, which the grandmother tried to improve. Until his family left the joint household the child was a yo-yo in relation to the three women.

Toilet training occurred between the ages of 2 and 3 years, and night wetting continued into the fifth year. At the age of 5 Jim sustained a head injury in the occipital area, caused by a hammer pitched to him, and was hospitalized.

He had problems from the first day of school, when he misbehaved, was reprimanded by his teacher, and became the laughing stock of his class, establishing a precedent which persisted throughout his school years. While he was growing up, his father wanted him to participate in sports,

but his clumsiness frustrated these plans. However, he and his father were able to associate to some extent through the father's concern with electronics, and the father sometimes took his son on business trips. There were always many electrical gadgets at home for Jim to take apart and 'repair'.

Puberty and teenage years. At puberty Jim became preoccupied with death, and went from child guidance classes to private tutors to psychiatrists. As the time of his Bar Mitzvah approached, at the age of 13, he became pathologically religious. The rabbi found him difficult at religious classes, and finally told his parents that he could no longer attend. So Jim was never Bar Mitzvahed, and he was greatly hurt by being denied what had been given to his brother and friends. At the age of 14 he was given nine shock treatments, and at 15 he was sent to a military school, apparently to be disciplined. His left and right incoordination increased, and since this made marching drills impossible for him, he had to leave school in three weeks.

Before his hospital admission he had developed a 'friendship' with a boy who had an interest in photography. Presumably this boy was the only friend who ever came to visit Jim in his home. Once when Jim and his friend went skating, Jim fell down. His friend laughed at him, and this depressed him greatly. Shortly after this, Jim went into a camera shop and declared his wish to buy an expensive camera. When his father refused to buy it, he went into an uncontrollable, violent outburst, and had to be taken to the family physician to be calmed down with medication. The family physician referred him to the hospital where he came to the attention of the authors.

The treatment, and appearance of the machines

The first 18 months of his therapy were conducted in the 21-bed psychiatric unit of a university hospital. For 3 months after hospitalization he was treated as a day-patient. Following this, he was seen three times a week for 11 months as an out-patient until the treatment came to a 'technical interval', as will be described later.

His initial sessions with the therapist, the junior author, consisted mainly of Jim's descriptions of various types of electrical instruments with which he seemed to be too much preoccupied most of the time, and of talk about technical or 'scientific' things in general. This intellectualization, or

'mechanization', set the pace for his therapeutic sessions; he spent hours talking about tape-recorders, EKG machines, encephalographs, FCC regulations, walkie-talkies, etc. He would often re-express everything in 'lay terms' so that the therapist might understand. At the beginning of his hospitalization, he treated the therapist as though he thought him stupid, and spoke of him in the terms he used to describe his father.

Self-observation appeared only when he talked about his 'constipated mind', which would not permit entrance or exit of thoughts, or of his 'private little world', which he felt to be shrinking rapidly. He felt worthless, hopeless and desirous of 'ending it all'.

Sometime during the first 2 weeks of his hospital stay, his father brought him a new portable transistor tape-recorder. Jim recorded his thoughts on tape and asked the therapist to listen to the recording instead of listening to him. He annoyed other patients, particularly elderly women, by holding out his receiver to record their conversations. He was in a four-bed room at the time of his admission, and, like the children in his school, his room-mates began to ridicule him. Soon after admission he was transferred to a single room, where he remained until the end of his hospitalization. He was, however, afraid to go to sleep there. At night he was afraid of 'seeing hands'. Nurses were asked to sit with him at night before he fell asleep. The therapist tried giving him sleeping medications, but none were very efficacious. Later, when Jim had established a meaningful relationship with his therapist, the night fears disappeared.

It was clear from the beginning that Jim, who used language defensively, could not understand the therapist's interpretation of his conflicts as expressed in adult language. In order to allow an alliance to develop between them, the therapist did not interfere with the patient's interest in machines, nor cut off his unique discussions, for which the therapist was well prepared by having had two years of engineering school training before going into medicine.

During his second month of hospitalization, Jim showed gross symbolic signs of wanting to identify (through imitation) with the physician. He obtained a stethoscope, wore white pants, and placed a 'Private - Do Not Enter' sign on his door. At the same time he began to accumulate

machines and gadgets until his room looked like a repair shop.

Shortly after his second month of hospitalization he built his 'sonic anaesthesia machine' to produce 'white noise'. The sound of an electric shaver was tape-recorded and transmitted to his ears through a stethoscope. A later refinement was the addition of earphones and a special device, purchased by his father, to produce 'white noise' at varying intensities. It would allegedly produce sleep, the idea having come from a magazine article about anaesthesiology. At this time Jim spent most of his time sleeping, and during this narcissistic withdrawal the therapist once more had difficulty relating to the patient through the usual verbal communications; the main therapeutic effort then involved protecting Jim from the responses of 'fed-up' patients and ward personnel.

Towards the end of the third month of Jim's hospitalization his father brought him a camera and photographic equipment. A darkroom was found, and the patient and therapist began to work there developing pictures. At this point treatment consisted mainly of the time they spent together in this occupation. Jim took several photographs of the therapist, but these did not come out.

Jim made further attempts to look like the therapist, who left on a week's vacation four months after Jim's admission, following a period of particularly intense involvement between patient and therapist. When Jim learned about the holiday he began drawing circuit diagrams for a new machine which he called a 'shock box'. During the separation another physician cared for Jim, and at the same time a medical student became his 'pal'. When the student left the psychiatric service, Jim once again reinstated the therapist as the 'good one'.

Jim then became generally concerned about his body image, wanted the therapist to help him build himself up, and was insistent about having a corn removed from his foot. Besides asking for medical assistance, he started seeking support in growing up and becoming a man. Signs of his identification with his therapist increased. He started imitatively smoking a pipe, and showed a competitive attitude by buying tobacco superior to the therapist's. He would not verbalize his wish to grow up and be like the therapist, nor his competitive feelings; attempts to secure verbal

clarification caused him to withdraw to his 'mechanization'.

Eight months after Jim's admission to the hospital his father could no longer afford full in-patient therapy and Jim became a day-patient. He built a new machine while separating himself from the security of in-patient life. The machine consisted of a metal rod with a square plate at each end, wrapped in tinfoil electrodes. The plates were wired to a generator of radio waves sensitive to metal objects, and Jim called it an 'underground metal detector'. It was to be used to chart underground steam tunnels near the hospital so that Jim could find his way into the nurses' dormitory, and also to locate Confederate war relics. Jim and another boy made explorations into the network of steam tunnels in a search for a secret passage into the dormitory. They were caught, and got into brief legal trouble.

As a day-patient Jim lived in an inexpensive apartment. There were difficulties with his parents' acceptance of the continuation of his treatment. A few days before he left the hospital, pruritis of the trunk and arms appeared: he scratched continuously during interviews. When the therapist interpreted the connexion between the pruritis and separation anxiety, the symptom disappeared; this seemed to be the first time that the patient had responded markedly and rapidly to verbal interpretation.

After leaving the hospital, Jim began to communicate less and less about his activities to the therapist, who found it difficult to learn what his patient was doing from day to day. Jim developed a sarcastic attitude, sessions were full of silences, and the therapist felt he was being controlled by the patient, who, by the ninth month of treatment, demonstrated a definite splitting mechanism. Before visiting his parents elsewhere he would make the therapist an especially 'bad object', and achieve comfortable feelings with the parents, now seen as 'good objects'. Once more he did not seem to understand the verbal interpretation of this process.

During this month he got a job as pharmacist's assistant, but soon began to complain about the demands of his boss, who became a 'stupid father'. The adult responsibility was too much for him, and he quit after a few weeks.

About this time, at age 17 and still a day-patient, he became infatuated with a girl who had been a patient on his ward. She was sexually

more mature than he, and took only a passing interest in him. Rejected, Jim traded his camera for a more expensive one, which he used very little, but which he demonstrated to the therapist, inviting him to use it. The rejection also occasioned his hallucinating an alarm clock by his bed which began bleeding and then disintegrated. His lampshade also appeared to bleed, and he smashed it violently. He was hospitalized for a night, and not long after this crisis came another, brought about by the last-minute cancellation of his hour with the therapist, whose wife was having a baby. Jim was told by other patients the reason for the cancellation. He became highly anxious, and felt unreal. He responded to these treatments by 'merging' with the therapist. At this time the therapist was using his camera, and during supervision hours there was confusion as to whom the camera actually belonged.

After a delay of 2 months in obtaining another job, and in the eleventh month of his treatment, Jim began grinding lenses in a local optical company. Unfortunately, the course of his treatment was changed for financial reasons. He continued to be treated by his therapist on a three-times weekly basis, but he was no longer a day-patient, and his ties with the hospital were broken.

During his preparation to sever ties with the hospital two machines went into the planning stage. The first, the 'muscle stimulation machine', was to be a variant of the 'shock box', but instead of having electrodes merely for application to the skin surface of the arms it had small needles for insertion into the muscles to induce contraction. The second machine was a 'hypnosis machine', which appeared immediately before Jim was discharged from day-patient status to become an out-patient. He talked grandiosely about his plans to hypnotize 30 or 40 people at one time, wanted his therapist to instruct him in the techniques of hypnosis, and started reading a book on the subject.

During this time he was, because of financial need, prematurely working in the adult world. Meeting this world head-on for 2 months was very stressful for him. Attempts to interpret the genetic aspects of the situation, i.e. making the adults 'stupid' (father transference) or not trustworthy (mother transference) were unsuccessful, mainly because of excessive difficulties arising from the external world. On two exceptionally stressful days Jim felt 'merged' briefly with his

grinding machine; as he placed his hands on it it would seemingly envelop him so that he could no longer demarcate any boundaries between himself and its surface.

The 'sleep machine' appeared towards the end of the 12th month. It consisted of an electronic device which passed a weak pulsating current through two wires attached to electrodes - damp pads applied to the eye-lids as he reclined. It was the last of a series of machines built by Jim; he claimed it was superior to that of the Russian doctor who had originated the idea.

At the beginning of the 14th month Jim left his job at the optical company after he began to see his employer as 'stupid'. Before leaving this job he redirected his energies toward using his skills for repairing machines rather than for building them, and set up a small shop in his apartment. He advertised his services by placing announcements on bulletin boards in the hospital and soon began receiving record-players, radios and even Geiger counters for repair. In the 14th and 15th months after the start of his treatment he began repairing radios and tape-recorders in a commercial shop.

The story was much the same as before. Working full-time with adults, he soon encountered difficulties with his employer, whom he regarded as 'stupid'. The employer would not tolerate Jim's arrogance and dismissed him after 2 months. Three months later, at the end of the 18 month of treatment, he became a projectionist in a local cinema. There he encountered none of the previously experienced problems with authority figures, probably because the work is done in isolation in a projection booth. However, at this time his attitude towards the therapist became one of heightened resentment, and this did not respond to interpretation. While he was working under someone, he saw him as a 'bad object'; now that he was working in isolation, he made the therapist the 'bad object', an intruder in his narcissistic world.

Jim discontinued treatment 'until further notice' at the end of the 23rd month, despite the therapist's insistence that he needed further treatment. He remained in the small university town, however, and for many months regularly attended the meetings of a social group made up of ex-patients. Thus in a sense he kept in contact with the therapist indirectly.

At the time of writing, 15 months have passed

since Jim 'proclaimed his individuality' and brought the treatment to a 'technical termination' or 'interval'. During this time he has continued to be a projectionist at the same cinema. Once, 7 months after cessation, he came to the therapist to obtain a statement of eligibility for a driver's licence. Two months later he was met in a social setting by the therapist's supervisor, the senior author. Apparently, at age 19 he is a sociable young man far different from the mechanistic, boring youth he had been before. Physically, he has changed from a clumsy, uncoordinated child into a typical young man. He may now be seen around town with his girl friend. While he appears to be well, our ideas about the core of his problem, especially his narcissism, fragmentation, splitting and externalization, which he does not verbally understand, require further examination.

A BRIEF FORMULATION OF THE CASE OF THE 'MECHANICAL BOY' AND ITS TREATMENT

The case. Since Jim's 'fingers were blue' at the time of birth, and a head injury occurred when he was 5, we considered the possibility of organic difficulties affecting his internalization of his early relationship with the environment, and his left-right incoordination. Neurological and EEG examinations were negative. During treatment we came to the conclusion that even the possibility of organicity did not outweigh the importance of the symbolic expression of left-right incoordination in respect to bisexual difficulties and ambivalence (Volkan, 1964). As treatment progressed, and as the patient became involved with machines, his coordination difficulties disappeared.

We took into consideration the family's communal life as another circumstance of possible significance to his psychopathology. During the first 10 years of Jim's life there seem to have been too many 'mothering figures'. He viewed the aunt as angry, and sometimes sadistic, the grandmother as warm and indulgent. The mother, who had probably suffered from a post-partum depression and who was so frequently involved in family quarrels, was so self-centred, and so resentful

of her son's problems that she does not seem to have been able to help him to individuate. It would appear that the bickering, fighting, anxious figures in the patient's early environment did not allow him to integrate the internalized experience with the environment, or to go successfully through the separation-individuation phase in order to establish his own individuality. Whenever he was rejected by one 'mothering figure', Jim would go to another one, externalizing the 'badness'. This pattern was seen repeatedly during his treatment; when the therapist went on vacation, he became 'bad', while Jim transferred the 'good mother' image to the temporary therapist.

It was difficult for Jim to learn socialization in his family setting, especially since the aunt considered him to be inferior to her children. At the oedipal level, his father's attempts to encourage participation in sports had been frustrated by the child's clumsiness, although the two had been able to associate to some extent through the father's electronic business. Jim's involvement with machines was closely related to his effort to identify with his electronically orientated father, and the father's role as an identification figure played an important part in the development of his unique ego defences. The attempt to identify with the father was also used to combat the bickering, hostile nature of early ego introjects. The process, however, could not be wholly successful because of the pre-oedipal pathology.

If Jim's development had taken a normal course, his identification with his father would have evolved along with the completion of his superego. However, as Volkan (1968) suggested elsewhere, patients like Jim appear to be constantly attempting various stages of ego and superego formation along introjective-projective lines without finishing the task. It appeared that when the child arrived at the oedipal phase with unresolved pregenital psychopathology an important goal of the inadequately formed ego-superego was to find an answer to the pregenital problem. Jim was seen as 'reaching up' to a higher level of

psychosexual development, or a more individuated level of the separation-individuation series to find an answer to problems of the earlier levels. Later we will discuss the patient's use of machines in respect of this phenomenon. Another complication in Jim's family situation was that in actuality the father was a weak man, especially when confronted by women. At the oedipal level Jim related to his father with a strong ambivalence, and then came to view the older man as 'stupid'. This aspect of his problems appeared again during the treatment, and when he was forced to face the adult world in the course of obtaining and holding jobs.

At the pubertal age, during which there is normally a resurgence of early pregenital and oedipal issues, the patient again did not have a chance to resolve the conflicts. He turned to God as a father substitute, and at the age of 13 became pathologically religious. His inability to accomplish the Bar Mitzvah was another blow to him, and drew him further into secondary narcissism.

His psychological make-up affected his visual apperception; when taken into a room for the first time, he would stand at the door, blinking, as though he had become a camera and were taking snapshots of the room in its several aspects. He seemed to find this necessary in order to relate to it or to the people and objects it contained. Jim's libidinal drive was maintained at the oral level, as if he were 'object hungry' (Szasz, 1957; Volkan, 1968) in searching for objects in the environment to introject. He was also trying to maintain control over his aggressive drive towards the outside world while seeking to manage the distance between the outside world and himself. His lack of success in these efforts led to frequent temper-tantrums.

The treatment. Loewald (1960) relates psychoanalytic treatment to normal personality development: he suggests that ego development resumes in the psychoanalytic process. He states:

The analyst, through the objective interpretation of transference distortions, increasingly becomes

available to the patient as a new object. And this not primarily in the sense of an object not previously met, but the newness consists in the patient's rediscovery of the early paths of the development of object-relations leading to a new way of relating to objects and of being oneself... The child, by internalizing aspects of the parent, also internalizes the parent's image of the child... In borderline cases and psychosis, processes such as I tried to sketch in the child-parent relationship take place in the therapeutic situation on levels relatively close and similar to those of the early child-parent relationship.

In treating Jim we followed this 'new object' idea. It is applicable in the treatment of borderline and psychotic patients, where, especially at the beginning of treatment, one attempts modification of the early introjects by means of internalization of the therapist and crystallization of new ego identifications (Boyer, 1967; Volkan, 1968). To illustrate more clearly the possibility that operating on archaic levels may be useful in adulthood in the treatment situation, the following quotation from Cameron (1961) is helpful:

It may still be possible for a patient who is operating at archaic levels part of the time to use the equivalence of early partial identification in ways that a more maturely developed psychic system could not. It may even still be possible... to introject massively with archaic completeness in adulthood and then be able to assimilate the new introject as an infant might, so that it disappears as such, but some of its properties do not.

In summary, at the beginning phase of the treatment our plan was to provide Jim with a 'constant object', a therapist who would *therapeutically* insist upon being different from the 'archaic introjects' (Volkan, 1968). Since the patient's relationship to objects was, according to the earliest mode of relationship, along introjective-projective lines, the introjection of the therapist was inevitable.

However, there seemed to be difficulty in verbal communication with the patient in the usual therapeutic sense. Balint (1958) has addressed himself to this issue, i.e. how the adult language is not an adequate and

reliable means of communication for patients who are at what he called the level of the 'basic fault'. In Jim's treatment, while the therapist *therapeutically* stood by the patient, in fact he allowed him to use a mechanical analogy or 'do it yourself kit', and the patient made attempts to resolve his intrapsychic conflicts and to change his object relationships through the device of creating and working on machines.

A REVIEW OF THE OBJECT RELATIONSHIP ASPECT OF JIM'S MACHINES

Three special circumstances should be recalled as introduction to this section of the paper: (1) Jim's father was a distributor of electric equipment, and the patient had access to many kinds of electrical gadgets; (2) the therapist had a background in engineering and an interest in photography, and (3) the patient had had nine electric shock treatments 2 years before admission. These are important considerations in elucidating the meaning and function which machines had for the patient.

A chart is provided to show the time sequence of the appearance of the machines in relation to the course of the treatment (see Fig. 1).

Tape-recorder. The first machine, introduced during the first 2 weeks of Jim's hospitalization, was a tape-recorder, which was not created by him. Jim changed the objects in his environment by holding the machine between himself and other objects (people) and part-objects (voices), filtering relationships with the environment in or out. The tape-recorder permitted Jim to keep the therapist at a distance while at the same time relating to him. Thus Jim, like Tommy (Ekstein, 1966), could maintain a 'meaningful close relationship with optimum distance'. At this level the therapist represented the early mother, as part or total object (mother transference). Another aspect of the device was Jim's ability to 'collect' the voices of patients, usually elderly women, representing his early mothering figures - his unmended introjects - and to bring them to

the therapist-father to find a solution – to mend the fragments (father transference).

Sonic anaesthesia machine. This machine, the first created by Jim, appeared shortly after his second month of hospitalization. As with the tape-recorder, with the new device he was in control of opening and shutting off the outside world and thus changing it in his omnipotent way. Both machines could also be used as a 'stimulus barrier', enabling the patient to take refuge in secondary narcissism through withdrawal. Similarly, the use of the stethoscope of the sonic anaesthesia machine to 'collect' heartbeats may have indicated his wish for fusion with a 'good' mother.

exhibited great fear when any sudden sound of high intensity was heard; here also we can see temporary identification, the machine being seen as a counterphobic defence against the noise or a protection against the introject grandmother.

Before creating this machine Jim had temporarily but intensively identified with the therapist, bringing to him the fragmented early mother introjects by means of the tape-recorder, although the actual oedipal father could not fight the women in his environment, and the original internalized oedipal father could not help to bind the early introjects. At the time the sonic anaesthesia machine was introduced, however, we believe that the

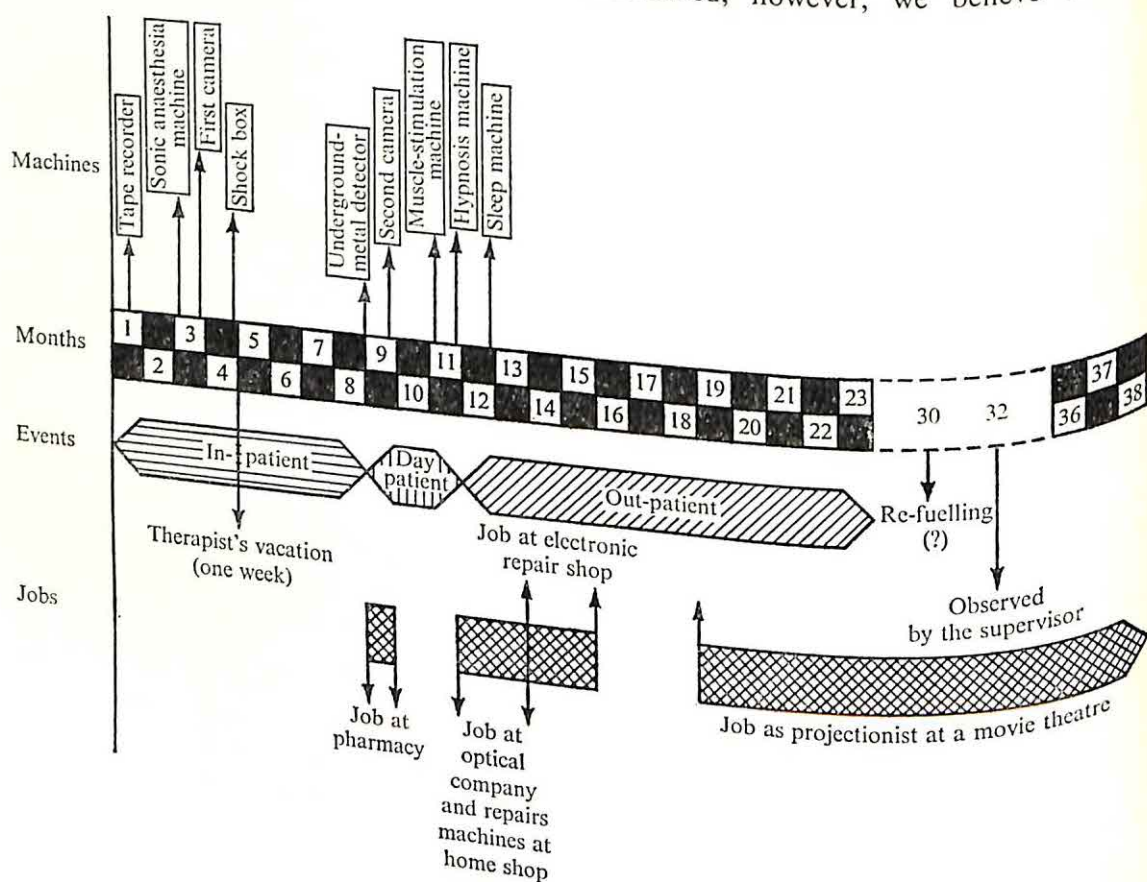


Fig. 1

There was another aspect to this machine from the genetic point of view. The grandmother who kept Jim during his early years was terrified by thunder and lightning. Jim

therapist/father was perceived as omnipotent by the patient since the patient was projecting his own feeling of omnipotence over the therapist.

First camera. After receiving his camera at the end of the third month of hospitalization, Jim used it as an organ for internalization. Among the 300 pictures he took, those of the therapist were the only ones which failed to print. Jim blamed the developing solutions, but we felt that this outcome relates to his anxiety, derived from primitive fantasies of incorporating the therapist. As representative of early introjects, or a less 'contaminated' person, he is regarded by Jim with ambivalence. Dynamically, while the love part took the therapist in, the hate part destroyed him. It is inevitable that in transference neurosis or transference psychosis, as the case may be, the therapist will represent the archaic transference representatives. It is extremely important, we felt (Volkan, 1968), that at the beginning of treatment with psychotics and those with the borderline personality organization the therapist therapeutically insist on being different from the archaic transference representatives. This manoeuvre usually fosters the later development of a more effective observing ego on the part of the patient. Toward this end the patient and his therapist spent long hours together in the dark-room developing pictures.

Jim used the camera to control what came in and what did not come in to his own world, as he had done with the tape-recorder and the sonic anaesthesia machine. We are reminded of Fox's (1957) photographer, whose camera was also used to satisfy incorporate strivings. The photographic activities of Fox's patient represented a primitivization of his ego function affecting all of his relationships to objects outside of himself; the same thing applied to our patient's photographic activities.

Shock box. We saw this machine 4 months after Jim's admission, when the therapist took a week's vacation following an interval of close involvement with the patient. It represented a machine used to give electric shock treatments. Dynamically and structurally, the creation of the shock box was the archaic superego's answer to Jim's aggressive drive.

The patient was angry with the therapist for leaving him, and simultaneously the aggression was projected on to the therapist, who, in Jim's fantasy, could retaliate; therefore the shock box was in the service of protection. To complete this process, the patient identified with the aggressive 'retaliating' therapist. Besides this attempt to combat the instinctual aggressive drive, there was also an effort to turn a passive experience into an active one.

Another motive behind the creation of this machine was to please the physician who cared for him during his therapist's absence, and who customarily used electrical machines in treating alcoholics. At this time the genetic aspect of Jim's early life – his role as a yo-yo among mothering figures – became very clear. the vacationing, unavailable therapist became a 'bad mother', while the other physician became a 'good mother'. There was also a medical student on the scene who was an extension of the 'good mother'.

Underground-metal detector. This machine was built 8 months after admission, when the patient had to leave in-patient status. At this time he showed that the experience of physical separation became symbolized, representing intrapsychic separation from the symbiotic mother. Such phenomena were described by Volkan & Corney (1968).

Mechanisms pertaining to oral, anal and phallic phases seemed to be involved in this machine. Again we examine Jim's attempts to deal with a problem – at this point separation anxiety – through the creation of this machine, which expressed his wish to go back into his mother. He and another patient were caught by the police when they attempted by using it to find a way into the nurses' dormitory. Jim's idea of locating war relics with the machine might indicate the anal aspect of finding power and handling the separation. On a higher level, Jim's expressed curiosity about female genitalia was possibly involved; however, this possible aspect was not examined in the treatment situation.

New camera. After being rejected by his girl friend, and after reacting to the birth of the

therapist's child, Jim attempted to 'merge' with the therapist in order not to face rejections. The new camera as 'visual introjection' equipment was used together by patient and therapist. Bion (1959), following Klein's ideas, talks about 'a normal degree of projective identification'. The therapist must have the capacity to introject the patient's projective identifications long enough to modify them. Those who are influenced by Mahler (1968) talk of a degree of symbiotic relatedness. It was during this time that the processes described occurred intensely in therapy, and they became clear in the supervisory hours when the therapist exhibited confusion about ownership of the camera.

Muscle-stimulation machine. This represented dynamically the mobilization of Jim's ego in an attempt at restitution following a threatened loss – the preparation to sever ties with the hospital. This machine was never actually completed. He hoped to find auto-erotic stimulation by creating the machine as an extension of himself. When the stimulating mother or penetrating father were lost, he could create his own parents. On the other hand, we see this machine as a continuation of the shock box, representing a repetition of the desire to master previous shock-treatment experience in order to manage the anger caused by impending separation.

Hypnosis machine. This appeared immediately before Jim became an out-patient; once again a separation stimulated the creation of a machine. This was an extended version of the sonic anaesthesia machine, and it transmitted white noise to several persons simultaneously. The direction of the white noise, previously directed inward, had changed. The hypnosis machine represented Jim's omnipotent defence against separation, but now he had turned passivity into activity, and identified with the aggressor. That is, now he was the therapist (hypnotist) and in fantasy he could actively hypnotize the others.

Sleep machine. The sleep machine represented Jim's omnipotent defence against the overwhelming stress coming from the outside

world and his own inner tension. At this time he merged with his machines and went into total symbiotic relatedness with his environment as a defence against finding himself in the adult world. Through the wish to sleep there was a wish to withdraw into secondary narcissism.

Work on machines. After the sleep machine no more machines were built. Jim's involvement with machines altered; its adaptive aspect became more realistic. His work on them might represent his intrapsychic reconstructive attempts.

When he became a projectionist at the end of his 18th month of treatment, clinical observation indicated that there was 'work pleasure' (Hendrick, 1951) in his use of machines. The conflicts about his object relationship were still present, but they were now projected outward as with aggression. One could readily see the omnipotent fantasy aspect of this object relationship in his work as a projectionist. It was akin to his previous fantasies of hypnotizing numbers of people; now he could keep the eyes of the audience glued on the movie screen. With this job he seemed to achieve a rather successful externalization with adaptive values, and this was the best he could now handle. The therapist at this point was viewed as someone who would interfere with the patient's compromise, and clinical observations indicated that in his job Jim became rather conflict-free, his skill gaining secondary ego autonomy. He interrupted his treatment at the end of the 23rd month.

DISCUSSION

In our 'mechanical boy' his involvement with machines at one level was closely related to his effort to identify with his father-therapist. He responded to his father-therapist along introjective-projective lines. The first machines – the tape-recorder and the cameras – were introjective. Later, the hypnosis machine and his activity as a projectionist were seen as projective involvements. Jim attempted, in the more benign

atmosphere of the treatment situation, to reach a father by means of a 'do it yourself kit', as he would originally do during the phallic phase of his life.

In his original developmental stage, Jim had come to his attempts at identification with his father with unresolved pregenital psychopathology. In fact, the most important task given to his inadequately formed ego and superego was to find a resolution for the pregenital problem. He was seen as 'reaching up' to a higher level of psychosexual development to find answers to problems of earlier levels. The 'reaching up' for the sake of solution of earlier level problems is a futile attempt and becomes symptomatic. Here we can quote from Schafer (1968) for similar instances.

Pre-oedipal pathology interferes with the development of the normal oedipal conflicts, renunciations, and identifications; it also interferes with the establishment of an adequate superego and of aim-inhibited, sublimated, or desexualized interests. Thus, the entire process of establishing adaptively useful internalizations is impeded. All this means that it takes considerable ego strength to reach, sustain and transcend the oedipal situation, which means to have skills, perceptivities, and motivational resources to organize relations with genital mothers and fathers and identify with them.

So far what we have said reminds us of Balint's (1955) concept of 'progression for the sake of regression'. Balint describes two types of men with different attitudes towards objects: (a) the ocnophil, who, by clinging, can reassure himself that he and his objects are still one, inseparable, and (b) the philobat, who has accepted the separate existence of objects, but whose underlying fantasy probably is that the whole world, apart from the few accidental hazards, is a kind of loving mother. He writes:

The progression is acquisition of the consummate skill necessary for dealing with reality. The aim of this progression or the acquisition of the skill... is to enable one to regress through the state

which may be described as in a way forgetting altogether about the world around oneself... This state... may be correctly described... as a simultaneously introjective identification with the partner and projective identification of the partner with oneself. But at the same time it is obviously also a regression to the state of primary love... it is equally a progression to the acquisition of a skill in order to induce the object or even the whole world to accept the role of cooperative partner.

Therefore Jim's initial involvement with machines in treatment is a kind of progression, (a) representing his attempt to reach up and identify with the father in order to find a solution to pregenital problems, (b) representing his attempt to find a solution by the actual use of machines as an extension of himself, to deal with the archaic objects. For example, the tape-recorder and his sonic anaesthesia machine were used by him to control the distance between self-representations and internalized or externalized archaic object-representations. Thus changing the objects and their internal representations, he was in control of the switch to shut off the hazards and take in the good.

The white noise in his machine appears to be a stimulus barrier. Freud (1920) stated that, for the living organism, protection against stimuli is almost a more important task than its reception. Intensive external stimuli which last long can flood the organism, and this is experienced passively. Jim's use of the tape-recorder and his first invented machine, the sonic anaesthesia machine, protected him from the stimuli of the external world. He used these machines also as perception apparatus. As Fenichel (1945) stated: 'The construction of a perception apparatus, protecting against too intense stimuli, brings about a change from passivity to activity.' In Jim's later involvement with cameras their functions were like those of the tape-recorder and the sonic anaesthesia machine. The gratification of voyeuristic and exhibitionist impulses through use of the camera was there, but never gained importance. This was also

true of Fox's patient (1957). He wrote: 'Photography had become a regressive substitute for vision, and his camera served as a mechanism for the control of visual intake for the establishment of psychic distance.'

Jim was using his machines to relate his objects either along introjective-projective lines or along passive-active lines in order to make some attempts in psychological development. Most of his machines were built as responses to separation - when his equilibrium of object relationships was threatened and he wanted to undo the separation by his omnipotence. Like Balint's philobat, he believed that skill with machines would be sufficient to cope with all hazards and dangers. Balint wrote that the philobat changes himself while acquiring his skill, but then proceeds to use it for changing the world. Jim also exhibited other characteristics of a philobat, i.e. he talked about a wish to experience the thrills of parachute jumping and high-speed motorcycling.

Examination showed that there were links between all these changes. The sonic anaesthesia machine was the precursor of the hypnosis machine, just as the latter was the precursor of the sleep machine. Also, in the sleep machine we see elements of the shock box. The physical aspects of the machines were actually linked. There were also psychological links between the meanings and functions of machines in the series.

The process of this patient's concern with machines, and the development of his creativity and skills, has been described in psychoanalytic literature in several terms. These include the traditional concept of sublimation and the newer concepts of neutralization, secondary ego autonomy, and so on. Starting with Freud (1923) in classical psychoanalysis, one finds the assumption that sublimation is intimately related to internalization. Fenichel (1945) summarizes four characteristics of sublimation: (1) inhibition of aim, (2) desexualization, (3) complete absorption of an instinctive drive into its sequelae, and (4) alteration within the ego. Fenichel continues,

'All these qualities can also be seen in the results of certain identifications, or, for example, in the process of formation of the superego.' We have already explained how this process was seen in our 'mechanical boy'.

Sandler & Joffe (1966), who have suggested certain novel aspects of the concept of sublimation, state: 'There seems to be good evidence that there is always at least a weak and subliminal link with bodily sensations during even the highest form of mental activity (mental activity concerning skills).' It is their hypothesis that 'the development of an ego activity or skill does not in itself constitute sublimation; rather, it can be used for purposes of sublimation'. In order for an activity or skill to be considered sublimation, the achievement must provide a 'reduction in the demand for work imposed by the instinctual drive in the form which is much more "distant" than the primitive mode of drive discharge, which is accompanied by feelings of pleasure removed from crude instinctual pleasures'. In addition, Sandler & Joffe also suggest the activity or skill must be invested with a constant 'value cathexis' which they liken to object constancy.

In Jim's case his achievement as a projectionist received a value beyond the level of simple need satisfaction. However, close examination of his achievement, an adaptive externalization, shows 'links' to the primitive modes of achievement - from attempts with machines at establishing 'stimulus barrier', with obvious bodily sensations, to relating objects through 'osmosis'. The stretching and contraction of these links on one spectrum can, from an energetic point of view, be conceptualized as oscillation in the process of desexualization and deaggressivization, on the one hand, and resexualization and re-aggressivization, on the other. What is understood is that neutralization itself is progressive or regressive, and that it is therefore dynamic rather than static. However, it would be clinically more rewarding to study 'distancing', as it is called by Sandler & Joffe, between the original sensual affects accom-

panying somatic stimulation and discharge and the achievement of skill usage by the application of general metapsychology. For example, in our 'mechanical boy's' involvement with machines and his developing skills we took into consideration also dynamic, genetic, structural, and adaptive points of view. Further slow-motion studies of similar clinical material are needed to explore metapsychologically such a spectrum with its contractable and stretchable links.

SUMMARY

The psychological aspects of man's involvement with his machines are reviewed. From a clinical point of view, there are patients who are influenced by machines, which are felt to be separate from them; conversely, there are patients who feel one with machines. The latter are the 'mechanical people' who have developed only the precursors of the 'influencing machines'.

A 16-year-old 'mechanical boy' employed or constructed a series of machines during his treatment. In this paper the multiple meanings of his involvement with machines, along with his

attempts at internalization, are observed. Among the multiple meanings the following aspects are enlarged upon: his wish to 'reach up' in psychosexual development for the sake of finding solutions to pregenital problems, his wish to control the distance between self- and archaic object-representations, and his attempt at reconstruction of the equilibrium of object relationships at the time of separation.

'Reaching up' for the sake of early problem-solving is a futile attempt; it becomes symptomatic, and this was the case in our 'mechanical boy'. During treatment, with the use of his 'do it yourself kit', the patient tried to reach the mechanically orientated oedipal father and at the same time resolve the problems with pregenital mothers. He ended his treatment when he reached a compromise adaptation, again with the use of machines, and saw that the therapist was a threat to the compromise. Moreover, the patient was viewed as a true philobat since through changing his machines he changed himself and his relationship to the world in which he was trying to adapt. Thus it was established that there were 'links' between the ongoing psychological processes as well as 'links' between the physical aspects of the machines which represented the psychological processes.

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The therapeutic and developmental functions of psychotherapy*

BY HEINZ H. WOLFF†

In this paper I shall consider one of the many controversial issues in the field of psychotherapy, namely the relation between two of its different, though interrelated, aims and functions. On the one hand, psychotherapy is one of many forms of treatment directed towards the cure, or at least the amelioration, of symptoms and illnesses; this I shall refer to as its therapeutic function. On the other hand, psychotherapy is concerned with promoting the psychological development of individual persons who, as the result of hold-ups in their personal development, encounter difficulties in their lives and interpersonal relationships, and who may or may not have developed overt symptoms or disturbances of behaviour as a result; this aspect of psychotherapy I shall refer to as its developmental function.

Historically speaking, there have been considerable fluctuations in the relative emphasis placed on these two functions. When Breuer & Freud (1895) described the use of hypnosis and of the cathartic method in the treatment of patients with hysterical symptoms their primary aim was symptom removal. In this respect they followed the medical tradition which was then, as it largely still is today, directed towards treating symptoms and illnesses rather than persons, and to do so in as short a time as possible. Over 40 years later Freud (1937) in 'Analysis Terminable and Interminable' discussed the changes which had come about in the intervening years and which had led to psychoanalyses

lasting not a few months but many years. Here he says: 'there is no question of shortening the treatment: the object has been completely to exhaust the possibilities of illness and to bring about a change in the personality'. In the same paper he makes a distinction between therapeutic and character analysis. I shall return later to the question whether this distinction is justifiable, but it is clear that when Freud wrote 'Analysis Terminable and Interminable' psychoanalysts had distinguished between the therapeutic and developmental functions of psychotherapy, as I have chosen to call them.

Jung (1929), in a paper on 'The Aims of Psychotherapy', makes a comparable distinction when he says: 'what the doctor then does is less a question of treatment than of developing the creative possibilities latent in the patient himself'. His emphasis on the developmental aspects of psychotherapy also finds expression in his use of such terms as 'self-realization' or 'transformation' and 'individuation' of the personality (Jung, 1934).

More recently, the developmental function of psychotherapy has been stressed by Winnicott (1963), who speaks of the need for 'management' and of providing a 'facilitating environment' for seriously ill or regressed patients in order to allow the normal maturational processes to take their place in the patient's ego development. In a paper on 'Psychiatric Disorder in terms of Infantile Maturational Processes' (1963) he says:

When a psycho-analyst is working with schizoid patients (call it psycho-analysis or not) the insightful interpretation becomes less important, and the maintenance of an ego-adaptive setting is essential. The reliability of the setting is a primary experience, not something remembered and re-enacted in the analyst's technique.

* Chairman's address to the Psychotherapy and Social Psychiatry Section of the Royal Medical Psychological Association, November 1970.

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Guntrip (1961, 1968), basing his views partly on those of Fairbairn (1952) and Melanie Klein (1946), has stressed that the development of the individual does not occur in isolation but always in relation to persons or objects, both internal and external; he therefore emphasizes that, if progress in personal development is to be made during psychotherapy, the real relationship between therapist and patient which goes alongside and beyond the transference relationship is of fundamental importance. In 'Object Relations Theory and Psychotherapy' (Guntrip, 1968) he says:

It is a matter of being a sufficiently real person to the patient to give him a chance of becoming a real person himself, and not an assemblage of defences, or a role, or a conforming mask, or a mass of unresolved tension. If the patient cannot meet with personal reality in the therapist he cannot give up his struggle to keep going a spurious reality by means of internal bad object relations and external forced effort.

Alongside, and partly as a reaction against, this increasing interest in the developmental aspects of psychotherapy, others, both inside and outside the analytical schools, have tried to improve the therapeutic function by looking for techniques which would lead to better and quicker results in treatment. Ferenczi's (1920) attempt to use more active techniques than was customary in orthodox analysis is well known, and more recently Malan (1963) has described briefer forms of psychotherapy based on focusing attention on specific psychodynamically defined areas and on early more direct interpretations, especially of transference manifestations. The development of behaviour therapy, and especially Wolpe's (1964) early exaggerated claims that neurotic symptoms can be successfully treated in 90 per cent of cases without paying attention to the patient's personality problems – claims which have been modified by Lazarus (1963), Marks (1969) and Strupp & Bergin (1969) – have further challenged psychotherapists to evaluate their techniques; this has led to renewed interest

in the therapeutic function aimed at symptom relief (Frank, 1961, 1968; Gelder *et al.*, 1967; Strupp & Bergin, 1969), all the more so as it is very much easier to study the outcome of treatment in terms of changes in symptoms and outward behaviour than in terms of personality development and inner dynamic changes.

THEORETICAL CONSIDERATIONS

Before discussing the differences and similarities between the psychotherapist's two main functions, i.e. his therapeutic function directed towards symptom relief and his developmental function directed towards progress in the patient's personality development, I shall have to deal with some theoretical aspects concerning the problem of how these two aspects of his work are related to each other. The question of how the two can be combined and integrated within the actual clinical practice of psychotherapy I shall consider later.

Developments in the biological sciences and in medicine in particular have shown us that it is no longer possible to consider the function of one cell in isolation but that its function is interrelated with the function of other cells in every multicellular organism; similarly, the function of one organ in health or disease must be considered in relation to other organs and in the context of the organism as a whole. This basic principle applies even more to the psychological sciences; any one psychological function, say perception, is dependent on and influenced by the psychological state of the person as a whole, especially by his present mental state and his expectations. Similarly, a symptom or disturbance of behaviour cannot be considered in isolation but is inevitably related to the particular person's behaviour as a whole, taking into account his past experience and his present relationships to others in the social network in which he functions. The development or removal of a symptom inevitably affects other functions of the person concerned, either for better or for worse, and will also influence his social

relationships. To consider a symptom in isolation, although this may be necessary temporarily in the course of treatment and research, can only be done at the cost of ignoring other related aspects of the person's psychological functioning and object relationships. Mair (1970), himself a psychologist, has recently drawn attention to the fact that the proper field of study both for experimental psychologists and for psychotherapists is persons and not segmented processes. Speaking of research done by psychologists he says:

Learning, motivation and thinking are studied experimentally while the person who learns, is motivated and thinks, is left on one side for eventual synthesis in some unnamed place outside the laboratory. . . it is the person who comes for treatment and not his disembodied population amalgamated processes.

While learning theories are perhaps most prone to this conceptual error, to a lesser extent classical psychoanalytic theory has had a similar tendency. For example, modern analytical and especially object relations theory has taught us that to trace a hysterical symptom back to the oedipal situation and then to treat it at that level only, ignores the fact that how a developing child passes through the oedipal situation will depend on all earlier stages of his development, including his experiences in the earliest infant-mother relationship; and whether or not a hold-up at the oedipal stage will or will not later on lead to symptom formation will be equally dependent on his later development and interpersonal relationships. The division between so-called oedipal and pre-oedipal cases, requiring classical or modified forms of psychoanalytic treatment respectively, is therefore an artificial one; and so is the distinction between so-called ordinary and character neuroses and hence between therapeutic and character analysis.

The question which the psychotherapist has to ask himself, therefore, is not whether he is dealing with either a neurotic symptom, or a developmental and character problem, but rather how the symptom or abnormal

behaviour is to be understood in the context of the person's development and previous learning experiences, and within the social context in which he lives. Such understanding can only be arrived at after full investigation in interviews of the dynamics of the person concerned and of his interpersonal relationships. In the light of such psychodynamic understanding the therapist can then decide whether the particular person can best be helped by limited forms of treatment directed mainly at the symptom itself, be this through a more limited psychotherapeutic approach, or behaviour therapy, social manipulation, with drugs or by a combination of two or more of these; or whether he is motivated and capable of working with the therapist at a deeper level in an attempt to help him get beyond certain early hold-ups in his personal development.

The basic assessment on which such decisions will have to be based must include an understanding of the unconscious processes involved. It is the discovery and the detailed exploration of unconscious processes and their bearing on the person's inner and outer object relationships which constitutes one of the most fundamental contributions which psychoanalysis has made to our understanding of the function and behaviour of persons rather than some of the superimposed metapsychological theories which Freud himself, and his successors, have had to modify again and again, and whose usefulness and theoretical validity may not survive the test of time, even in their present form. Some behaviour therapists and non-analytical psychotherapists still seem to have difficulty in acknowledging the importance of unconscious mental processes, even though no neurophysiologist would hesitate to acknowledge that much of what happens in brain functioning, and thus affects our experience and behaviour, takes place without entering our conscious awareness. This slow but long overdue recognition of the importance of unconscious phenomena by everyone who deals with human problems and mental illness may be less due to an

value. Patients come to us to achieve certain results, and they rightly insist that we do all we can to do so as quickly as possible. What I want to point out, however, is that the psychotherapist's doing to function by itself is not enough. It has to be based on an attitude which stems from the developmental function of psychotherapy to which I will turn next.

The developmental function

Analysts and most psychotherapists realize that to achieve lasting changes in treatment depends in many cases on helping the patient to resolve and overcome hold-ups in his personal development and consequent out-of-date patterns of reacting and behaving. It was Winnicott (1963, 1965) who pointed out that to achieve this aim in the case of severely ill, especially schizoid, personalities depended on allowing them in reality to re-experience in treatment those early phases of the mother-child relationship in which disturbance of development had occurred, owing to some failure in the facilitating environment. It is the therapist's task to provide for the patient conditions which are safe enough to allow him to regress and to make up for the earlier failure so that he can make, as it were, a new beginning in his development. This task makes special demands on the therapist. Winnicott (1965) compares this function of the psychotherapist with that of a mother, who through her primary maternal preoccupation is able to be with her baby and thus support it in its ego development:

My thesis is that what we do in therapy is to attempt to imitate the natural processes that characterize the behaviour of any mother of her own infant. If I am right it is the mother-infant couple that can teach us the basic principles on which we may base our therapeutic work.

This led Winnicott and Guntrip to stress the necessity for the therapist 'to be there as a real person with the patient, to hold him, as it were, like a mother emotionally speaking holds her baby by her state of being'.

My thesis is that, whilst the psychotherapist's

therapeutic task mainly depends on his 'doing to' function, his developmental task, i.e. his ability to help patients make progress in their personal development, depends on what I will call his *being with* function. I would go further and say that being with is necessary for all psychotherapeutic work, not only in the case of patients with particularly severe personality disorders. In fact the doing to function will be properly effective only if it is based on the right kind of underlying attitude of being with the patient.

The following are some of the characteristics of the being with function. It demands a high degree of empathy and sensitivity to what the patient is experiencing; the psychotherapist must be able intuitively to grasp the deeper meaning of the patient's verbal and also, and especially, of his non-verbal communications, of the likely significance of what it means when he is silent, goes to sleep, gets restless, confused or reacts with his body rather than in words. He must be reliably there as a person and genuine in his therapeutic concern for his patient, but he must be honest with himself and his patient when he has failed or partially failed, as he often and inevitably will do in this difficult area of psychotherapeutic functioning. In this area of his work he must resist the temptation to make too many interpretations or to be manoeuvred by the patient or others to start doing something to the patient when being with him as a real person is felt to be more important for the time being. He must not become too concerned with symptoms and abnormal behaviour and must instead remain primarily concerned with the developmental aspects of the psychotherapeutic process, even when this takes time. His attention in other words will be directed more towards inner psychic realities and developments than to outward behaviour and to the achievement of quick results in treatment. His relationship to his patient will be similar to what Buber (1958) has called the I-Thou relationship; it will also resemble the psychotherapeutic relationship described by Rogers (1961) as one

which is characterized by being real, genuine and based on empathic understanding and acceptance of the patient in his own right.

Recently Truax & Carkhuff (1967) have published their research findings which showed that the following three personal characteristics of psychotherapists are significantly correlated with satisfactory outcome of treatment: accurate empathy, non-possessive warmth and genuineness. Following Winnicott's view concerning the similarity between the mother-infant relationship and the psychotherapist's relationship to his patient, it is interesting to note that these three characteristics identified by Truax and his co-workers are in fact those which a mother needs to have towards her own baby; these three qualities of accurate empathy, non-possessive warmth and genuineness would seem to belong to what I have called the being with rather than the doing to function. In the case of a mother and her baby we would not hesitate to describe her inner attitude in one much simpler term, namely as loving her baby; this suggests that loving the patient, or at least having a deep liking for him as another human being needing help, may be one important curative factor among others in the therapeutic relationship, a factor which would be part of the therapist's being with function. Several analysts other than Winnicott have drawn attention to this. Thus Margaret Little (1960) speaks of 'basic unity' and of the analyst being 'sufficiently one with his patient', Balint (1965) speaks of 'primary love', and Nacht (1962) stresses the importance of the therapist's 'real, deep inner attitude'. More recently, Klauber (1968) has emphasized the significance of the analyst's personal characteristics in the therapeutic process.

On the other hand, as has been pointed out by Caine & Smail (1969) in *The Treatment of Mental Illness*, psychotherapists and psychoanalysts, in their desire to be accepted as scientists, have often been slow in acknowledging the importance of the influence of their own personality, especially of liking or

even loving their patients, in their psychotherapeutic work. They have instead preferred to emphasize mainly, or even entirely, their supposedly neutral attitude and the transference aspects of the relationship, and all those other functions of their work which I have described as belonging to the doing to rather than the being with function; they have done so presumably because to admit that one's own personality and one's personal involvement with the patient might be an important aspect of psychotherapeutic work, was thought to be unscientific. Actually it is, of course, the opposite of scientific to deny and to fail to study these realistic facts any more than any others. The wish to do so arises out of the misconception that only the kinds of data used in the physical sciences are truly scientific. That in actual fact even in the work of the natural scientist his own personality influences his discoveries and observations, I have referred to earlier when discussing Medawar's analysis of the scientific process. If, as is becoming increasingly clear, such personal factors as truly being with the patient play as important a part in psychotherapy as do the less personal factors described under the term of doing to, a truly scientific attitude would demand that they, too, be acknowledged and studied with proper care. This does not, however, mean that the highly personal and subjective being with aspects of psychotherapy are the only ones that matter. It would, for example, be wrong to conclude from Truax & Carkhuff's findings that it is accurate empathy, non-possessive warmth and genuineness *alone* which constitute the essence of psychotherapy, and that knowledge of psychopathology is irrelevant, or that Freudian or any other analytical or learning theory concepts are unimportant in psychotherapeutic work; or even that loving the patient is all that is necessary for successful psychotherapy as has been claimed by Halmos (1965) in his book *The Faith of the Counsellors*. The reverse is the case. Accurate empathy inevitably depends on one's ability to understand accurately how the mind works. This implies

detailed knowledge of and skill in interpreting the relevance of past experience and of intrapsychic and interpersonal phenomena.

THE THERAPEUTIC (DOING TO) AND
DEVELOPMENTAL (BEING WITH) FUNCTIONS IN
CLINICAL PRACTICE

I shall discuss the relative contributions of the being with and doing to functions and their interaction under two subheadings: the diagnostic interview, and formal psychotherapy.

The diagnostic interview

We tend to think of diagnosis as separate from treatment but most psychotherapists will have had the experience of having seen a patient once, or perhaps twice, apparently purely for diagnosis, only to hear later that the single interview has made a sufficiently powerful impact on the patient to help him resolve some basic developmental problems in his life. I will give you one example.

A man of 31 came to see me complaining of impotence since the birth of his first child, a son, six months ago. He was a successful personnel manager in a large firm but for the last few months he had found it difficult to work; with these symptoms went general feelings of anxiety and depression; he feared that he might lose his job and be unable to provide for his wife and child, and that if he remained impotent his marriage would break up.

In the interview which lasted just over two hours he was at first polite and impersonal; he answered questions but volunteered little information and it took over an hour before I got anything like a picture of his present life situation and past development. He had succeeded in making me ask him many questions but at no time did I feel that I had got anywhere near his real feelings. In fact, he had behaved rather like a distant personnel manager. As a result I began to feel frustrated and doubtful whether or how I could help him; I therefore asked myself whether I was

beginning to share with him feelings that he also had but was unable to express. What helpless, frustrated feelings might he have been concealing from himself and others beneath his apparently successful role as personnel manager and husband prior to the birth of his son? I knew by now that he was an only child, that his father had died when he was four, and that he had lived with his mother until his marriage three years ago. I therefore commented that I wondered whether it was really true that, as he had told me, he had not missed his father as a child and had been content to live alone with his mother after his father's death, and then to have had to support her for many years. Perhaps he had found it a greater strain than he had liked to admit to have his mother lean on him since he was a small boy?

This tentative interpretation led to a marked change in the interview. He became tearful and for the next hour he talked whilst I listened; gradually a picture emerged of the child within himself, carefully concealed from everyone, his wife included. There was a little boy having to be strong after his father's death so that mother would not be upset by his own tears. In later years he had to be the good and helpful son, unable to express his anger with her for being possessive and for making demands on him, instead of letting him behave like a child, and later on as an independent man.

When we came near the end of the second hour and I knew that I would soon have to bring the interview to a close, I merely said that in this second hour he seemed to have shown me a sad and angry childlike part of himself that had not yet grown up and still wanted to be looked after, now by his wife, instead of always having to be the controlled grown-up man, the efficient personnel manager, managing as it were other people's lives, and now also the grown-up father of a son, whilst he himself had had no father and little real mothering since he was four. I added that perhaps he had allowed me to be like a father to him in the session and that this might per-

haps help him to become a father to his own son with less anxiety and doubt about himself.

As he was living in the north of England, where facilities for psychotherapy were difficult to find, I suggested he might let me know in a week or two how he was and whether he still felt in need of more help, or whether perhaps our talk had done something for him. I also told him that I would be glad to see him again if he wanted to do so. I heard nothing for a month. Then he wrote that he had felt sad but relieved on his journey back home, had for the first time been able to tell his wife how he really felt, and ten days after that he had been able to make love to her again. He felt no need for further treatment but added he was glad to know he could come and see me again if he wanted to. A year later he did in fact come and see me once to tell me that he had functioned well since, feeling happier in his marriage and more assertive in his work; he told me that they were expecting another baby and that he was enjoying being a father and being able to give his son what he himself had lacked in his own earlier life. He was a little tearful when he said this and we parted on that note. I still hear from him very occasionally so that the link has not been broken.

I told you about this patient in order to make a few comments about what can occasionally happen as a result of a single interview through the combination of one's being with and doing to functions. General psychiatrists might argue that he had recovered from a depressive illness but this would totally ignore why and how the so-called depressive illness arose and how the interview had helped him to recover. Classical analysts, on the other hand, might describe this as a transference cure only. Of course, transference played an important part here but what mattered was the real experience he and I had had together in the two hours we met, namely that in reality I had in the second hour made it possible for him to go back to being a small boy in front of me and to express feelings he

had hardly ever allowed himself to be aware of, and even less shared with anyone else. All this arose out of my being with function. At the same time I was conscious of what was happening and could put it into words at more or less the right moment; I interpreted his angry and his depressed feelings in relation to his mother and the loss of his father; at the same time I conveyed to him that I believed in his adult self, and expressed the hope that he might find it easier to function as the adult man and father he also was, now that he had acknowledged the existence of a child part within himself. All this arose out of my doing to function.

Once he had acknowledged the small boy and the presence of aggressive impulses within himself, it became possible for him to develop beyond an early hold-up in his emotional development. It is not always necessary in treatment to work through all those aspects of childhood development which have remained unresolved. For example, once this patient could make a new beginning, he seems to have been able to resolve the oedipal problems which had clearly been left unresolved when his father died, leaving him alone with his mother at the age of four. Time, too, was important here. I saw him for a full two hours and gave him time to make use of the interview afterwards, instead of doing something to him by arranging regular long-term treatment. This belongs to my being with function and so does the fact that he knows I am still there, as it were. And lastly, what I did out of my doing to function was only possible because I had fortunately been able to like him and to be with him when we met. Correct doing to depends on the right kind of being with. This is the main point I wanted to make.

Formal psychotherapy

Cases of the kind I have just described are unfortunately rare. Most patients will, of course, require much more detailed and sometimes, though not always, long-term formal psychotherapy. However, the main

principle, namely that correct doing to depends on the right kind of being with, applies to every psychotherapeutic session whether this be part of an analysis, or analytically orientated individual or group psychotherapy, or supportive psychotherapy. I can only refer to a few important issues here to illustrate this further. In each session the therapist needs to be sensitively alert to the possibility that the patient may be re-experiencing some vital moment of his earlier development. When this occurs interpretations are rarely needed; in fact they may interrupt the experience and create a new trauma. Silent, non-verbal acknowledgement or a brief comment, indicating that he understands and shares the experience with his patient, is more appropriate at such moments. Asking questions, requesting further free associations or making interpretations is better left until some later stage, either in the same or a subsequent session, because any of these doing to activities inevitably make demands on the patient's conscious ego functions which is inappropriate when one is communicating with the patient at a more primitive, early level of emotional experience. On the other hand, it is essential that the therapist retains, in his own conscious awareness, the insights he has reached at such moments so that he can verbalize them as soon as contact is being made again at a somewhat more adult level of ego functioning; otherwise the patient will be left in a prolonged state of infantile dependence and progress in development unnecessarily delayed. The therapist must be seen as someone who can reliably be with him, but also as an adult, able to understand, to interpret, to act, to be firm and on occasions even willing to take realistic action. In fact, taking a helpful realistic action on behalf of the patient may be a sign that the therapist is genuinely with him and concerned for him.

I recall a patient, a social worker, who at a certain stage of her analysis was threatened with dismissal from her post because she had gone through a period of depression which

had seriously interfered with her work; this threat arose just when she was making real progress in treatment. With her agreement, and after analysing the meaning of my intervention, I wrote a firm letter to her employers pointing out that they would not only be losing a valuable member of their staff but also that dismissing her now would jeopardize the results of two years' psychotherapy with me and might damage her further progress. As it happened, they kept her on, but, more important for her development, this 'doing to' behaviour – acting out on my part if you like – turned out to be a crucial experience in her analysis as it proved to her that I was with her and behind her in reality, something her own parents had never been able to be for her. Doing to can thus sometimes be an important sign of being with the patient.

On the other hand, I suspect that some of the commonly accepted doing to activities of analysts and psychotherapists may have the opposite effect. For example, too rigid insistence on punctuality, or on ending the session exactly after 50 minutes, may make the patient, perhaps rightly, see the therapist as an authority figure. These aspects of what could be called analytical discipline are sometimes more in the therapist's than in the patient's own best interests. They tend to resemble old-fashioned rigid toilet-training habits and may serve a superego function which may, as we know, make the patient's development as an autonomous person in his own right more difficult, especially if it recreates in reality a previous rigid, over-controlling attitude on the part of the patient's parents. The best guide how to handle these and similar problems in psychotherapy lies in our capacity to be with the patient with the right kind of understanding in the here-and-now situation.

Inevitably the therapist will often fail to be with him in the right way and at the right time; as Winnicott (1965) has pointed out, such failures are inevitable in the transference relationship where they will repeat earlier failures in real life. Such failures need to be

acknowledged by the therapist, whether they are failures in being maternal or paternal enough; real failures in understanding him; failure, as the patient will see it, to respond to his sexual or other impossible demands which is of course an inevitable frustrating aspect of any therapeutic relationship, or the therapist's occasional failure to control expressions of anger with his patient at the wrong moment. (At other times it may be appropriate and even helpful to show that one is angry with him.) Such failures must be acknowledged; the therapist must be prepared to be the target of the patient's anger and both must be able to forgive and to make reparation. These are all ways of genuinely being with the patient; but they must then be followed by correct interpretation, that is, by doing to which comes after being with. In this way the patient will again and again experience and recognize the good and the bad aspects of himself and of his therapist; in a successful case this will gradually allow him to accept the bad as well as the good, thereby reducing primitive splitting which is so basic a problem for everyone, but particularly for those who have got stuck at those early stages of development where splitting is the only mode of object-relating.

One further aspect concerns the ending of psychotherapy. If we see ourselves as functioning only in our therapeutic or doing to function we may consider that when the desired results have been achieved we have done to the patient what he needed and discharge him, as after any other form of medical or psychiatric treatment. If, however, we remember that we have also played a developmental role through our being with function it becomes important not to dismiss the patient totally but to continue to remain with him, as it were. In a sense, we shall do so in any case as after successful psychotherapy we shall survive in the patient's mind as a significant inner object or memory; but for many patients, if not most, it is important for them to know that we have survived in reality even after we have stopped seeing them. This must,

however, not take the form of possessively wanting to remain in touch with them, instead of setting them free to lead their own independent lives. To do so can be as harmful as total cutting off when treatment ends. But for them to know that, should they wish to communicate with us, we shall still be there and glad to see them, is a better ending for both therapist and patient than to end treatment on a note of finality; the latter would not be truly in the spirit of a real shared relationship which should have been mutually meaningful and important to both partners.

Lastly, one word about groups. Most of what I have said applies to group psychotherapy as well as to individual psychotherapy. In fact, to belong to a psychotherapeutic group provides a unique experience of being with, even though within the group many doing to and being done to experiences will take place between the individual members, and between them and the therapist (Wolff, 1967). Most patients in groups soon find that the group itself, through the cohesive atmosphere it creates, gives them a basic sense of security and belongingness. The shared experience of being together with other group members and the therapist creates feelings of mutual concern and this makes it possible for anger, envy, jealousy and sexual or other threatening feelings to be experienced and expressed. These doing to and being done to experiences which are so characteristic of what goes on in groups can then be interpreted by the therapist and used constructively by the group members. It is exactly because the group as a whole provides a safe being with experience on the basis of which a multiplicity of doing to and being done to experiences can be tolerated and utilized, that group psychotherapy provides such a unique setting in which further development can take place, often more effectively so than in individual therapy or analysis, provided always that what happens in the group is properly understood and interpreted by the therapist.

IMPLICATIONS FOR TRAINING OF PSYCHOTHERAPISTS

If the assumption is correct that psychotherapists need to fulfil two interrelated functions, namely that the correct way of treating patients by means of the doing to function depends on the right basic attitude of being with the patient in order to understand and help him with his development, certain conclusions can be drawn concerning the training of psychotherapists.

The ability to be with one's patients will to a large extent depend on the therapist's own personal characteristics; it clearly demands a considerable degree of empathy and sensitivity to other people's inner problems and their subjective experience. To be open to these areas of human mental life is only possible if the therapist is in touch with these areas within himself; those who are not will have difficulties in these respects and will function better when dealing with more clearly defined and objective aspects of human behaviour. They may feel more at home in the physical and biological sciences and in those aspects of medicine and psychiatry which depend on the methods of observation and research appropriate to these disciplines. This no doubt accounts for the fact that there is still, and probably always will be, a division amongst psychiatrists between those whose clinical and research contributions will be made mainly in the field of psychotherapy, and those who contribute mainly to descriptive psychiatry and to biological, social and epidemiological research. That is not to say that there will not be an intermediate group who can work in and contribute to both fields. In fact, it is the essence of a competent clinical psychiatrist to be able to function in both these areas but those who wish to specialize in the psychotherapeutic approach will necessarily fall closer to one end of this spectrum of human personalities.

It must, I believe, be accepted that to a considerable degree the being with function of a psychotherapist is the expression of a

natural gift, developed no doubt as a result of his own life experience and development.

Truax & Carkhuff (1967) rightly stress that greater and more systematic attempts need to be made to help psychotherapists develop the qualities of accurate empathy, non-possessive warmth and genuineness in relation to their patients; or, to put it differently, to increase their sensitivity and genuine understanding and concern for their patients' inner problems. But this cannot be done as a purely technical procedure; it needs to be part of a wider effort to diminish their defensiveness and thus to increase their awareness of their own and others' inner psychic experience. It will have to be accepted that only those who already have certain natural gifts in these directions are likely to be able significantly to improve their being with function as psychotherapists. It is from among these that future psychotherapists are best selected for special training.

On the other hand, the more technical doing to function and the ability to acquire what I have called psychodynamic understanding or knowledge of psychopathology can be more easily learnt even by those whose being with function is less highly developed. It is here that theoretical instruction and supervision of psychotherapy play a major role in training. Supervisors of psychiatrists, other doctors, students, social workers or psychologists learning psychotherapy are very aware of the fact that some of the trainees, whilst able to learn a great deal of technical expertise and psychodynamic understanding through supervision, may remain relatively less able to function sensitively in their being with function than others, even if, as should be the case, every effort is made in supervision to increase the trainee's sensitivity to his own as well as to his patients' inner psychic experience. Even personal psychotherapy or a training analysis will be limited in their effectiveness by the trainee's natural ability or lack of ability to develop his being with function. An undue emphasis on theo-

retical training and ego psychology may even have the opposite effect by focusing the trainee's attention on the conscious and rational as opposed to the unconscious and irrational aspects of human experience. This does not mean that the former should not be taught but their limitations must be recognized; and the need to do all that can be done to increase the trainee's sensitivity and self-awareness, i.e. his being with function, must be kept in the forefront of those responsible for training in psychotherapy. In this respect the supervisor's and, in the case of those who are undergoing an analysis as part of their training, the analyst's own ability sensitively to be with the trainee during supervision or in therapy will be the main factor which will determine to what extent the trainee's being with function develops further.

THE INSTITUTIONAL SETTING

I wish to end with a few comments on the importance of the institutional setting in which psychotherapy is conducted. Psychotherapy is being practised more and more in hospitals and clinics and the attitude of the institution as a whole is bound to influence the work of the psychotherapists or of the psychotherapy department within it, and *vice versa*.

General or psychiatric hospitals focus their attention necessarily on the treatment aspect of patient care, emphasizing diagnosis, treatment and early return to the community and to work. In other words, the emphasis is rightly on doing to. Psychotherapists working in such a setting will be expected to take part in this and, indeed, they have considerable contributions to make through their doing to function, their skills in psychotherapy and their psychodynamic understanding; they should, however, contribute not only by being responsible for treating a small number of patients in individual or group psychotherapy, but also, or even more so, by throwing light on a wider variety of patients' problems through assessment interviews, and also in

the general process of management of patients on wards, in out-patient departments, day hospitals and social rehabilitation units; they should also make their contribution in training programmes for general psychiatrists (Wolff, 1970) and research.

There is, however, a serious danger that as a result of the pressure exerted by the institution as a whole psychotherapists will neglect their being with function and thus pay less attention to the developmental aspects of their work. Psychotherapists working in hospitals need to maintain their concern with the developmental being with aspects of psychotherapy. In fact thereby they can in turn help the institution as a whole to remain concerned not only with the treatment of illnesses and community care but also with underlying personality disorders and associated intrapsychic and interpersonal difficulties of individual patients, and their problems of human development. These more long-term and personal aspects of psychiatric care would otherwise be in danger of being neglected in busy units expected to produce quick results through symptomatic treatment and social manipulation only. It is one of the functions of psychotherapists working in general hospitals or larger units to complement and counterbalance this tendency.

Basically this is the problem of our society as a whole in so far as technological advances, which can be seen so doing to activities, are in danger of being used without due attention being paid to their wider implications, often with disastrous results to individuals and society. Concern for individual persons and human values is essential, if these dangers arising out of one-sided technological developments are to be avoided. Such recognition of the importance of individuals and of human values is closer to man's being with than his doing to function. The fact that the correct doing to depends on the right kind of being with therefore applies not only to the discipline of psychotherapy but equally to medicine and psychiatry and ultimately to society itself.

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Some psychoanalytic research into the communication of meaning through language: the quality and magnitude of psychological states*

BY LOUIS A. GOTTSCHALK†

Psychoanalytic clinical theory provides a rich source of ideas and psychoanalytic practice affords ample empirical data towards determining how language conveys the concept of quality and intensity of various psychological states. This report describes some selected findings derived from a continuing psychoanalytic research project into the communication of meaning through language, principally spoken language.

This research programme might most properly be classified as applied psychoanalytic research, for it involves the application of psychoanalytic insights obtained from the clinical psychoanalytic situation to language behaviour occurring in many contexts outside the classical psychoanalytic procedure. The general problem with which this investigation deals is the accurate measurement of psychological states, a problem of equal consequence to psychoanalysts, psychiatrists, psychologists and behavioural and social scientists.

The measurement method chosen utilizes a function that is uniquely human, namely speech and its content or semantic aspect. Small samples of speech, as brief as 2 or 5 minutes, have been found sufficient to provide objective measures of various psychological states. The development of this method has involved a long series of steps. It has required that the psychological dimension to be measured (for example, anxiety or hostility) be carefully defined; that a unit

of communication, the grammatical clause, be specified; that the content, i.e. the lexical cues, be spelled out from which a receiver of the verbal message infers the occurrence of the psychological state; that the linguistic, principally syntactical, cues conveying intensity also be specified; that differential weights, signifying relative intensity, be assigned for semantic and linguistic cues whenever appropriate; and that a systematic means be arrived at of correcting for the number of words spoken per unit time so that one individual can be compared to others or to himself on different occasions with respect to the magnitude of a particular psychological state as derived from the content of verbal behaviour. The method requires also that a formal scale of weighted content categories be specified for each psychological dimension to be measured; that research technicians, other than psychoanalysts, be trained to apply these to typescripts of human speech (much as biochemical technicians are trained to run various complex chemical determinations by following prescribed procedures); that the interscorer reliability of two trained content technicians using the same scale be 0.85 or above (a modest but respectable level of consensus in the psychological sciences for these kinds of measurements). Moreover, a set of construct validation studies have had to be carried out to establish exactly what this content analysis procedure is measuring, and these validation studies have included the use of four kinds of criterion measures: psychological, psychophysiological, psychopharmacological and psychobiochemical. On the basis of these construct validation studies, changes have been made in the content

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categories and their associated weights in each specific scale in the direction of maximizing the correlations between the content analysis scores with these various criterion measures.

Construct validation is a step-by-step process that requires repeated re-examination and retesting, in new situations, of the constructs being evaluated. After initial validation studies were completed for verbal behaviour measures of the psychological constructs of anxiety, hostility out, hostility in, ambivalent hostility, social alienation-personal disorganization (the schizophrenic syndrome), a large variety of additional investigations were carried out using these verbal behaviour measures. These have provided considerable data on the ways in which such verbal behaviour scores relate to other relevant measurable phenomena. These data afford growing evidence as to how the constructs measured by these verbal behaviour measures 'fit' with other empirical data (Gottschalk *et al.*, 1958, 1960, 1961*a*, 1963; Gottschalk & Gleser, 1964; Gleser *et al.*, 1961).

The formulation of these psychological states has been deeply influenced by the position that they have biological roots. Both the definition of each separate state and the selection of the specific verbal content items used as cues for inferring each state were influenced by the decision that whatever psychological state was measured by this content analysis approach should, whenever possible, be associated with some biological characteristic of the individual in addition to some psychological aspect or some social situation. Hence, not only psychological but also physiological, biochemical and pharmacological studies have all provided further construct validation.

The details of these steps, including many reliability and validity studies and the specific investigations pinning down each point, have been published over the past 13 years. They have recently been collected in a book, written with my principal collaborator in this area, Goldine C. Gleser, Ph.D., a measurement psychologist, and this book describes many

newer unpublished investigations on the subject as well as a formulation of the theoretical underpinnings of this method (Gottschalk & Gleser, 1969). Psychoanalytically derived content analysis scales applicable to speech have been developed for measuring (objectively and precisely) anxiety, hostility (in or out), the capacity for human relations, social alienation-personal disorganization (schizophrenia), cognitive impairment, achievement strivings, dependency, dependency frustration, hope, health-sickness, etc.

Empirically derived steps for measuring the magnitude of psychological states

(a) Our work demonstrates that the relative magnitude of a psychological state can be validly estimated from the typescript of 2-5 minutes of speech of an individual, using solely content variables and not including any paralinguistic variables. In other words, the major part of the variance in an immediate psychological state of an individual can be accounted for by variations in the content of the verbal communications (Gottschalk *et al.*, 1958, 1961*a, b*, 1963, 1967; Gleser *et al.*, 1961; Gottschalk & Gleser, 1969; Gottschalk & Kaplan, 1958).

(b) On the basis of verbal content alone, the type and magnitude of any one psychological state at any one period of time are directly proportional to three primary factors: (1) the frequency of occurrence of categories of thematic statements; (2) the degree to which the verbal expression directly represents or is pertinent to the psychological activation of the specific state (for example, to say that one is killing or injuring another person or wants to do so is regarded as a more direct representation of hostile aggression than to say that one simply disapproves of another person); (3) the degree of personal involvement attributed by the speaker to the emotionally relevant idea, feeling, action or event.

(c) The degree of direct representation can be represented mathematically by a weighting factor. Higher weights have tended to be

assigned to scorable verbal statements which communicate feelings that, by inference, are more likely to be strongly experienced by the speaker. Completely unconscious or repressed feelings of any kind are not, by my method of weighting, considered to signify states of high magnitude, but rather to amount to zero or no feelings. This numerical weight, which is assigned to each thematic category, designates roughly the relative probability that the thematic category is associated with my construct of the psychological state. Initially, weights have been assigned deductively on the basis of common sense (as in the example *b2* above) or from clinical psychoanalytic judgement (as in *d* below). Subsequently, the weights have been modified and revised whenever further empirical evidence has been sufficient to warrant such a change (Gottschalk *et al.*, 1961*a*, 1963; Gottschalk & Gleser, 1964).

(*d*) The occurrence of suppressed and repressed feelings can be inferred from the content of verbal behaviour by noting the appearance of a variety of defensive and adaptive mechanisms. I have assumed that the verbal content of spontaneous speech, like dream content, contains the workings of primary and secondary process thinking, though speech employs presumably different proportions of these kinds of thinking than the dream. Thus the immediate magnitude of a psychological state is considered to be approximately the same, whether the affectively toned verbal thematic reference is expressed in the past tense, present tense or future tense, as an intention, as a conditional probability or as a wish. Some of the defensive and adaptive mechanisms signaling the presence of suppressed and repressed feelings in language are: (1) the psychological state or its associated ideation or behaviour attributed to other human beings; (2) the psychological state or its associated ideation or behaviour occurring in subhuman animals or in inanimate objects; (3) the psychological state and its equivalents repudiated or denied; (4) the psychological state and its equivalents

acknowledged but reported to be present in attenuated form.

(*e*) The product of the frequency of use of relevant categories of verbal statements and the numerical weights assigned to each thematic category provides an ordinal measure of the magnitude of the psychological state.

In other words, the greater the specific kind of feeling state of a speaker over a given unit of time, the more verbal references will be made, as compared to thematic statements of all types, to experiences or events of the types that have been classified in relevant categories with varying weights. Thus, multiplying the weight for the category by the number of references in the verbal sample classified in that category, and then summing all up the content categories pertinent to the specified state provides an ordinal index of the intensity of the feeling state.

(*f*) Individuals differ considerably in the rate of speech, and the same individual may vary in rate of speech from one unit of time to another. Since numerical indices of magnitude of emotion can vary with the number of words spoken per unit time, the numerical score derived from one verbal sample may be compared to the score derived from another verbal sample composed of a different number of words by using a correction factor which expresses the score of the feeling state of the speakers in terms of a common denominator, namely the score per 100 words.

Initially this correction was made by dividing the total raw score by the number of words spoken, and multiplying by 100. It was decided later that the most satisfactory and simplest way to take into consideration rate of speech is by adding 0.5 to the raw score, multiplying by 100, and dividing by the number of words spoken. This method avoids the discontinuity occurring whenever no scorable items have occurred in some verbal samples. It also provides a uniform transformation over all samples and, with rare exceptions, reduces the correlation between the score of the psychological state and the number of words essentially to zero.

A further transformation is made to obtain the final score, using the square root of the corrected score. This transformation is intended to reduce the skewness of the score distributions, thus making the measure more amenable to parametric statistical treatment. This square-root transformation tends to make the ordinal scale approximate the characteristics of an interval scale.

Schedule 1. *Anxiety scale*

1. Death anxiety – references to death, dying, threat of death, or anxiety about death experienced by or occurring to: (a) self (3); (b) animate others (2); (c) inanimate objects (1); (d) denial of death anxiety (1).
2. Mutilation (castration) anxiety – references to injury, tissue or physical damage, or anxiety about injury or threat of such experienced by or occurring to: (a) self (3); (b) animate others (2); (c) inanimate objects destroyed (1); (d) denial (1).
3. Separation anxiety – references to desertion, abandonment, ostracism, loss of support, falling, loss of love or love object, or threat of such experienced by or occurring to: (a) self (3); (b) animate others (2); (c) inanimate objects (1); (d) denial (1).
4. Guilt anxiety – references to adverse criticism, abuse, condemnation, moral disapproval, guilt, or threat of such experienced by: (a) self (3); (b) animate others (2); (d) denial (1).
5. Shame anxiety – references to ridicule, inadequacy, shame, embarrassment, humiliation, overexposure of deficiencies or private details, or threat of such experienced by: (a) self (3); (b) animate others (2); (d) denial (1).
6. Diffuse or non-specific anxiety – references by word or phrase to anxiety and/or fear without distinguishing type or source of anxiety: (a) self (3); (b) animate others (2); (d) denial (1).

Illustrative findings from the application of an anxiety scale

To illustrate the findings of this psychoanalytically derived method of measuring the intensity of any psychological state, I

will draw from applications of my simplest content-analysis scale, the anxiety scale.

The type of anxiety that this scale attempts to measure is what might be termed 'free' anxiety in contrast to 'bound' anxiety, which manifests itself in conversion and hypochondriacal symptoms, in compulsions, in doing and undoing, in withdrawal from human relationships, and so forth. It is likely that some aspects of bound anxiety are registered by this scale, particularly by means of those content items in the scale which involve the psychological mechanisms of displacement and denial. This bound anxiety is preconscious, is relatively readily accessible to consciousness, and is capable – along with grossly conscious anxiety feelings – of activating autonomic nervous system and central nervous system signs of arousal. There is evidence, in fact, that these anxiety scores reflect not only the subjective awareness of anxiety from the conscious and the preconscious level, but also that level of relevant autonomic arousal and the level of relevant postural and kinesic activity.

Anxiety has been classified, on the basis of clinical experience, into six subtypes: death, mutilation or castration, separation, guilt, shame, and diffuse or non-specific anxiety (see Schedule 1). It is true that the nature and sources of anxiety may be classified in other ways. Furthermore, I acknowledge that the content categories I have used are not always discrete and unique, but this circumstance is consistent with the impression that people may be experiencing different kinds of anxiety simultaneously. This procedure does not differentiate between fear and anxiety, since it is impossible to make this distinction on the basis of such short samples of verbal content alone.

In the classification of death anxiety has been included only those items dealing directly with death and destruction. Mutilation fear and anxiety, as the term has been conceptualized, is synonymous with castration anxiety, and the descriptive items on the anxiety scale pertaining to this type of anxiety

are derived from psychoanalytic psychology (Freud, 1926; May, 1950). The concept of separation anxiety and the descriptive items designating what references in speech are to be counted under this heading have also been derived from psychoanalytic psychology, and specifically from Bowlby (1960) and others. In the descriptive items differentiating between shame and guilt anxiety the work of Piers & Singer (1953) has been used.

Actually, the categories for the anxiety scale were selected by listening as an analyst to many people who were considered to be anxious and not anxious, and noting that these were categories of anxiety that were both relatively frequently present and readily identifiable. Further crystallization of the ideas for the descriptive features of the content items under each category heading came from listening to tape-recordings of hypnotically induced anxiety states*. In these tape-recordings student nurses told stories in reaction to the same Thematic Apperception Test cards while in a hypnotic trance and before and after it was suggested that each hypnotized subject was very anxious. The categories and descriptive details in Schedule 1 give the content items which were eventually selected.

The weights for each subcategory were assigned on the basis of principles I have discussed elsewhere, namely on the basis of the degree of personal involvement and degree of direct representation. These weights are, of course, approximations. The square-root transformation of these anxiety scores in our various validation studies appears to provide a scaling of anxiety by this verbal behaviour approach which has some earmarks of an interval instead of an ordinal scale. For example, when parametric statistics are used, as well as non-parametric statistics, in evaluating the relationship of our anxiety measures to other psychological, physiological, bio-

* These tape-recordings were lent to L. A. Gottschalk by Levitt, Persky and Brady, who made them in connexion with an investigation of anxiety (1964).

chemical and pharmacological variables, a comparison of the statistical indices usually shows negligible differences.

Examples follow of two coded and scored speech samples. These and most of the speech samples used in the illustrative findings were obtained by telling subjects that we were doing studies of speaking and conversational habits and getting them to talk into a tape-recorder for 5 minutes about any interesting or dramatic personal life experiences they have ever had (Gottschalk & Hambidge, 1955; Gottschalk, 1968; Gottschalk & Gleser, 1969).

The examples illustrate the system of scoring those clauses which have scorable anxiety items, with appropriate symbols designating each category in the anxiety scale (Schedule 1). The numbers in parentheses indicate the weights assigned to each scorable content item. The diagonal marks indicate grammatical clauses. (A detailed description and discussion of scoring procedures, with many examples, is given by Gottschalk *et al.*, 1969.)

ANXIETY SCALE: NORMATIVE STUDIES*

The overall percentile anxiety scores for several non-psychiatric patient samples combined ($n = 282$)† and also for 107 psychiatric out-patients and for 107 psychiatric in-patients are shown in Table 1 (Gottschalk & Gleser, 1969). From these distributions and from a validity study, it has been found that a score of 2.2 indicates moderate anxiety while a score of 3.0 or more is indicative of the presence of pathological anxiety.

Anxiety and intelligence. A statistical test of the verbal anxiety scores for 90 individuals

* The square-root score, corrected for discontinuity at zero, is the score used for norms and for all statistical comparisons.

† The samples used were the Kroger sample ($n = 94$), undergraduate college students ($n = 87$), psychiatric residency applicants ($n = 22$), Veterans Administration Hospital medical in-patients ($n = 29$), and private hospital medical in-patients ($n = 50$).

Verbal sample no. 1 coded for anxiety

Name of subject:
(Male psychiatric
in-patient)

Total words: 187
Correction factor: 0.5348

What do you want me to say? / I don't know
5a3
what to talk about. / Well, let's see... / I don't
5a3
know what to talk about, Doc. / Uh I've been here
for about four months / and uh had a pretty rough
time of it. / And and uh my wife, she wants me to
stay here / as long as I can. / I told her / I would. /
6a3
Our babies, they get on my nerves, my little
babies. / Sometimes I don't get no sleep. / (Pause)
2b2
Got a little cat at home. / It got hurt, / it got a
2b2
broken leg / and I had to get that fixed. / (Pause)
I had a pretty rough time of it. / My dad, I
1b2 3a3
lost my dad in '54, / now only got two brothers
3a3
living. / And they never come to see me. / I guess/
4a3
it's pretty much my fault. / And uh my wife she
she changes her mind all the time. / I think / she's
6b2
kind of nervous too. / She thinks / she hears
4b2
people saying bad things about her. / I get sort of
6a4
frightened and scared about it all. / I don't know /
what else I can tell you. / That's all / I can think
of. /

employed at the same company (Kroger)
revealed no difference between males and
females in average anxiety, but a significant
negative trend in anxiety with IQ level
($P < 0.05$), the lowest IQ group having the
highest anxiety score ($r = -0.28$). These data
are shown in Fig. 1. This difference is probably
not due to IQ and/or education *per se*; rather,
speaking extemporaneously involves a task
for which individuals of lower IQ sometimes
feel inadequate.

Tabulation of verbal sample no. 1
coded for anxiety

Correction Factor (C.F.) = 0.5348

Subcategory	Total weight (W.)	Raw score (W. × C.F.)
Death		
1b2 × 1	2	1.07
Mutilation		
2b2 × 2	4	2.14
Separation		
3a3 × 2	6	3.21
Guilt		
4a3 × 1	5	2.67
4b2 × 1		
Shame		
5a3 × 2	6	3.21
Diffuse		
6a4 × 1		
6a3 × 1	9	4.81
6b2 × 1		
Total.....	32	17.11
17.11 × ½ C.F. = 17.38		
Square root = 4.17		

Anxiety and sex differences. While no significant sex difference has been found for overall anxiety in our sample of non-psychiatric subjects, some interesting differences have occurred in the type of anxiety expressed as indicated by the separate category scores for anxiety. When these were analysed separately, again using the square-root transformation, it was found that females had significantly lower average scores than males in the categories for 'death' and 'mutilation' anxiety, and significantly higher average scores on 'shame' anxiety. In fact, for females shame anxiety was by far the most important category scored; whereas for the males, death, mutilation and shame were scored with about equal average frequency.

Sex differences in anxiety subscale scores were re-examined, using the total normative sample of 173 males and 109 females. For the larger sample, the females had significantly higher mean scores on separation and shame

Verbal sample no. 2 coded for anxiety

Tabulation of verbal sample no. 2
coded for anxiety

Name of subject:
(Male medical
in-patient)

Correction Factor (C.F.) = 0.5319

Total words: 188

Correction factor: 0.5319

Well, here I am again doing this. / If I knew
5a3

something to talk about / I could / I could / I could
tell it better. / I don't know / whether this goes
over to the Board of Directors or what / but I
5a3

do / the best I know for a poor uneducated old
man. / Everything I know about myself / I like to
5a3 4a3

keep to myself. / Well, maybe the law is trying to
4d1

find out about me. / I was never arrested before
4a3

in my life. / I'd like to get arrested sometimes /
4a3

just to see how it feels to go to jail. / I guess / I
5a3 5a3

sound / like I'm off my rocker. / But what little I
5a3

know, / why it ain't hardly worth the telling. /
That nurse, she came to get more blood this
afternoon. / I just held out my arm / she jabbed
2a3 2a3

me with a needle. / Seems like / I'll run out of
2a3 2a3

blood. / I won't have any left. / Been jabbed so
2a3

much now, / I got a black and blue spot in my
4a3

arm. / I don't know / what'll happen to me / after
3a3

I make these complaints. / So they might dis-
charge me / even if I am sick. /

anxiety and significantly lower scores on
death anxiety (see Fig. 2). Using the median
test, the difference in medians for shame and
separation anxiety are significant, the median
for females being higher. However, males
have considerably more high scores in death
anxiety, so that the difference is significant
($P < 0.05$) at the 75th percentile. There is also
a tendency for the males to have higher
mutilation anxiety.

Subcategory	Total weight	Raw score
Death	0
Mutilation	15	7.98
2a3 × 5		
Separation	3	1.60
3a3 × 1		
Guilt	13	6.91
4a3 × 4		
4d1 × 1		
Shame	18	9.57
5a3 × 6		
Diffuse	0
Total.....	49	26.06
$26.06 \times \frac{1}{2} \text{C.F.} = 26.33$		
Square root = 5.13		

Table 1. Percentile scores for the total
anxiety scale in three groups

	Non-psychiatric employees, students, medical in-patients (n = 282)	Psychiatric out-patients (n = 107)	Psychiatric in-patients (n = 107)
95	2.65	3.40	3.25
90	2.40	3.20	2.77
85	2.20	3.02	2.52
80	2.05	2.83	2.35
75	1.90	2.50	2.20
70	1.78	2.27	2.07
60	1.58	1.97	1.80
50	1.45	1.78	1.60
40	1.28	1.59	1.41
30	1.10	1.40	1.22
25	0.98	1.31	1.10
20	0.85	1.22	0.98
15	0.68	1.13	0.83
10	0.53	1.02	0.70
5	0.35	0.82	0.50
Mean	1.46	1.92	1.68
S.D.	0.71	0.82	0.81

Sex differences in the subscales were also examined in samples of 107 psychiatric out-patients and 107 psychiatric in-patients. For out-patients, the females again had significantly higher mean scores on separation and shame anxiety. The females were also significantly higher on diffuse anxiety. In the median test,

the sexes differed significantly only on shame and diffuse anxiety. There were no significant differences between the sexes in the in-patient sample.

Anxiety and age. The relationship between age and anxiety has been examined in several samples of adults. There is no evidence of a

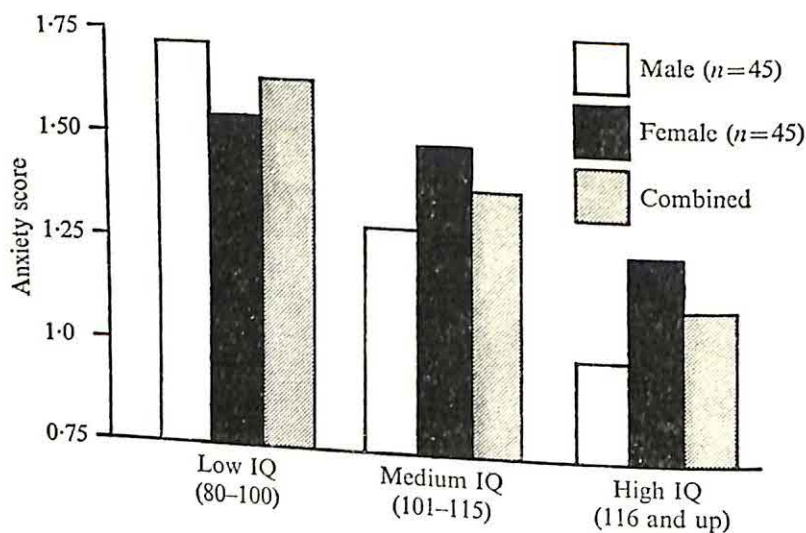


Fig. 1. IQ and anxiety scores for males and females.

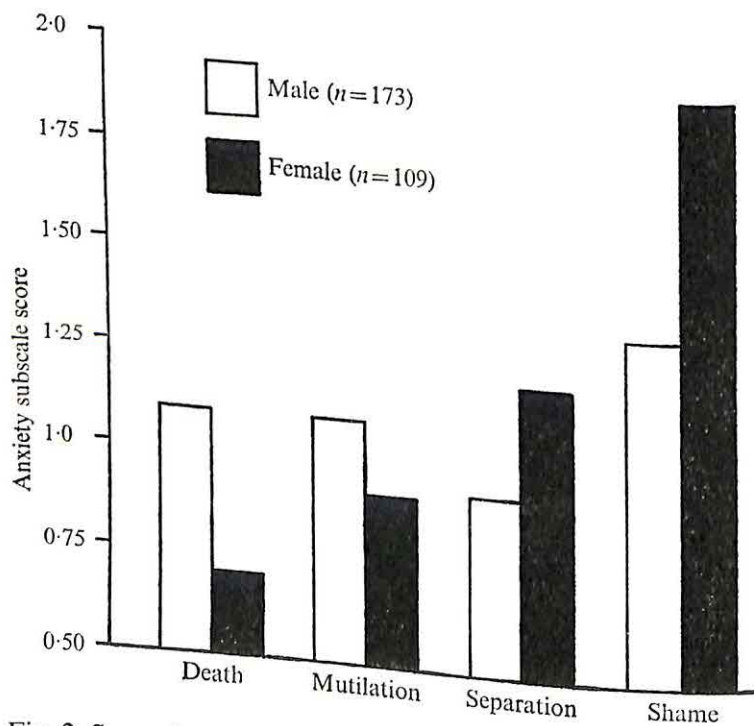


Fig. 2. Sex and anxiety subscale scores (non-psychiatric subjects).

linear relationship, correlations in all samples yielding non-significant coefficients. If there is a trend in anxiety with age, it is probably of a curvilinear form, increasing up to some age and then decreasing. However, the variance in anxiety scores accounted for by age of the subject at most would be quite small.

One subscale of anxiety, however, evidently increases consistently with age. In three separate samples we have found correlations of 0.25, 0.24 and 0.28 between age and death anxiety. Such a relationship makes considerable sense, since death appears increasingly important and threatening as one grows older. It is interesting that such a trend can be found in our data, inasmuch as death anxiety is one of the more infrequently scored subcategories of the total anxiety scale. Some additional evidence that the death anxiety score relates to the increased risk of dying is provided by the study of Miller (1965), who – using our content analysis method – found significantly higher scores on death, separation, shame and diffuse anxiety scores in a group of medical out-patients who had suffered, but recovered from, a myocardial infarction as compared to such scores from a group of out-patients with other medical diseases.

Intercorrelations among the anxiety subscales

The intercorrelations among the anxiety subscales was examined in three separate samples of individuals. For the most part these subscales tend to be uncorrelated, and hence may be assumed to measure independent psychological components of anxiety.

In the light of classical psychometric theory one might question whether it is meaningful to combine such non-correlated scores into a single score, let alone to speak of the resulting scale as measuring a single construct, anxiety. However, we have not assumed that scores on the separate subscales represent the same dimension, or kind of anxiety, but rather that they are interchangeable with regard to the *intensity* of anxiety. Thus it

might be noted that our total anxiety score can be conceptualized as the resultant magnitude of anxiety – that is, the square root of the sum of squares of the intensities on the separate subscales. We have so far ignored the direction of this resultant, which would depend on the relative magnitude of the separate subscores. Our choice makes it evident that we believe that the psychological and biochemical concomitants of immediate anxiety relate to the overall intensity rather than to the kind of anxiety that a person is experiencing.

Other relationships among verbal thematic content scores

Relationships between measures of anxiety and hostility (Gottschalk & Gleser, 1969). Correlations of the total anxiety scores and the anxiety subscale scores with the several hostility measures for two samples of people are presented in Table 2. It may be noted that total anxiety is only moderately correlated with total hostility out, hostility in, and ambivalent hostility* in the sample of employed personnel. The total anxiety score is somewhat more highly correlated with hostility in and with ambivalent hostility in the sample of psychiatric out-patients. While the correlation between anxiety and total hostility out is about the same in the two samples, it stems from a correlation between anxiety and covert hostility* in the sample of employed personnel, while the higher correlation is between anxiety and overt hostility* in the patient group.

Looking at the subscales, it appears that at least part of this shift may be due to the fact that guilt anxiety is positively correlated with overt hostility in the patient group but not

* *Ambivalent hostility*: Derived from verbal communications suggesting destructive and critical thoughts or actions of others to the self. *Overt hostility outward*: Derived from verbal communications about the self being hostile to others. *Covert hostility outward*: Derived from verbal communications about others being hostile to others.

Table. 2. *Correlations* between anxiety subscales and hostility scales derived from verbal samples*

Anxiety subscales	Number of words	Hostility in	Ambivalent hostility	Total hostility out	Overt hostility out	Covert hostility out
(a) Employed personnel (<i>n</i> = 94)						
Death	0.06	-0.01	0.28	0.23	-0.10	0.35
Mutilation	-0.01	0.08	0.18	0.46	0.04	0.55
Separation	0.12	0.16	0.18	0.15	0.16	0.06
Guilt	0.22	-0.09	0.05	0.26	-0.15	0.38
Shame	-0.31	0.43	0.02	-0.09	0.15	-0.13
Diffuse	0.16	-0.03	0.07	0.18	0.16	0.11
Total anxiety scale	-0.18	0.35	0.34	0.39	0.10	0.46
(b) Psychiatric out-patients (<i>n</i> = 50)						
Death	0.28	-0.10	0.16	0.36	0.08	0.38
Mutilation	0.19	-0.28	-0.02	0.11	-0.24	0.32
Separation	0.29	0.36	0.41	0.06	0.07	-0.04
Guilt	0.05	0.37	0.46	0.56	0.30	0.43
Shame	-0.23	0.43	0.02	-0.10	0.21	-0.32
Diffuse	0.06	0.54	0.38	0.07	0.16	-0.13
Total anxiety scale	-0.06	0.64	0.55	0.35	0.32	0.13

* Higher correlations are given in bold type for emphasis.

in the group of employed personnel. Furthermore, shame anxiety is significantly negatively correlated with covert hostility in the patient sample. In this regard it is interesting to note that shame is significantly correlated with hostility inward in both samples, whereas guilt is highly correlated with hostility out in both samples.

SOME EXAMPLES OF APPLICATIONS OF THE ANXIETY SCALE

A method of measuring the magnitude of any psychological state from small samples of speech, derived in large part from clinical psychoanalytic theory and practice, would not be worth the trouble of formulating its underlying principles or testing its reliability and validity, if it did not have applications well beyond its psychoanalytic precursors, its theoretical and empirical origins. I think that this method of measuring psychological states from the content analysis of short samples of speech has the scientific applica-

tions which justify the time and work that have been invested in its development. The major applications are outside the psychoanalytic situation, although it has been spawned by psychoanalytic practice which has spawned the ideas from which the method has been generated. Again, taking our very simplest content analysis scale as a prototype, namely the anxiety scale, let me cite briefly several studies which illustrate some uses of the method, studies which heretofore would have been impossible to carry out because of the lack of just such a measurement procedure and technique.

Correlations between anxiety scores and skin temperature changes

A group of 12 high-school boys, 16 to 17 years old, gave four verbal samples (in response to standard instructions to talk about any interesting or dramatic life experiences) on each of two separate occasions while continuous measurements of skin temperature were being taken (Gottlieb *et al.*, 1967). The

first 5-minute verbal sample was taken prior to hypnotizing the subject, whereas the subsequent three samples were obtained while the subject was in a hypnotic state. Anxiety scores from the six verbal samples obtained under hypnosis were correlated with the decrease in skin temperature occurring during the giving of the verbal sample for each student separately, using a rank-order correlation. Ten of the 12 correlations were positive ($P < 0.04$), yielding an average intrasubject correlation of 0.31.

In another study, examining the correlations between 5-minute sequences of two psychotherapeutic interviews and skin temperature (Gottschalk *et al.*, 1961*b*), a significant correlation was found between the anxiety scored in each 5-minute interval and the decrease in skin temperature from the beginning to the end of each 5-minute interval (Gottschalk & Gleser, 1969, p. 278).

Anxiety scores from dreams and inhibition of penile erection with rapid eye movement sleep

Karacan *et al.* (1966) studied the relationships of penile erections during episodes of rapid eye movement (REM) sleep and the anxiety scores derived, by our method, from the tape-recorded dreams reported upon awakening from such periods of sleep. A statistically significant association was found between anxiety scores from such dreams and the lack of penile erections.

Studies of relationships of emotions of plasma lipids

A natural-history study (Gottschalk *et al.*, 1965*b*) disclosed different relationships between several types of emotions and blood lipids in a group of 24 men who had fasted 10–12 hours. Findings were cross-validated in a study of a second group of 20 men. Anxiety scores had a significant positive correlation with plasma free fatty acids (FFA) in both groups – a sign of catecholamine (adrenergic) secretion in individuals fasting for this period of time – whereas three types of hostility indices had essentially zero cor-

relation with FFA. More anxious men tended to have higher FFA levels and sharper rises in FFA than non-anxious men in reaction to venipuncture and free associating for 5 minutes. There was evidence for positive correlations between triglyceride levels and both anxiety and hostility inward scores, as well as for total hostility outward scores and levels of blood cholesterol. In contrast to studies where higher levels of emotional arousal have often been involved and no differential relationship has been found between blood lipid levels and the kind of emotions one is experiencing, plasma lipid levels in this study were found differently related to anxiety than to hostility at relatively low levels of acute arousal.

Anxiety levels in dreams: relation to changes in plasma-free fatty acids

Blood samples for determination of plasma-free fatty acids were obtained throughout the night by means of an indwelling venous catheter. The first blood sample was drawn at the onset of rapid eye movements and a second after 15 minutes of these eye movements. Subjects were then awakened and asked to relate their dreams; a third sample was drawn 15–25 minutes later. Anxiety scores derived from 20 dreams of nine subjects had significant positive correlations with changes in free fatty acids occurring during the 15 minutes of REM sleep. (No statistically significant relation was found between anxiety and the changes in free fatty acids occurring from the time just before awakening to 15–25 minutes later.) These findings indicate that anxiety aroused in dreams triggers the release of catecholamines into the circulation, and these catecholamines mobilize proportional amounts of free fatty acids from body fat (Gottschalk *et al.*, 1966).

Anxiety and other psychological states in response to psychoactive drugs

Many studies have been done using this content analysis procedure in psychopharmacological investigations. In one study

involving a double-blind, crossover design (Gleser *et al.*, 1965), 46 juvenile delinquent boys were administered 20 mg of chlor-diazepoxide or a placebo. Using the content analysis of 5-minute verbal samples, significant decreases were found in anxiety, ambivalent hostility, and overt hostility outward, 40–120 minutes after ingesting the chlordiazepoxide. In another study (Gottschalk *et al.*, 1960) 20 dermatologic in-patients (10 men and 10 women) were given 16–24 mg a day of perphenazine by mouth for one week alternating with a placebo for one week, using a double-blind, crossover design. Analysis of the content of 5-minute verbal samples obtained from these patients showed a reduction of hostility out scores with perphenazine in 16 of the 20 patients ($P < 0.01$) and a decrease in anxiety scores among those patients who had elevated anxiety scores. Another study showed an increase in anxiety and overt hostility out scores derived from verbal samples, in-patients receiving the antidepressant drug, imipramine, as compared to a placebo (Gottschalk *et al.*, 1965a).

Studies of the content analysis of the speech of individuals administered psychotomimetic drugs (LSD-25, Ditrane, or psilocybin) or a placebo showed that people receiving psychotomimetic drugs do not have higher anxiety or hostility scores but do have significantly higher content analysis scores on a Cognitive and Intellectual Impairment Scale than when they receive a placebo (Gottschalk & Gleser, 1969).

The implications of these findings for psychoanalytic theory is that the neurochemical changes produced by these pharmacological agents are a functional decrease in utilizable catecholamines in the brain with tranquilizers such as chlordiazepoxide and perphenazine, and an increase in such catecholamines with administration of the antidepressant psychoactive drugs such as imipramine (Schildkraut *et al.*, 1968). Our demonstration that functional shifts in brain catecholamines influence levels of affects, and hence drives, is in line with Freud's predic-

tion (Freud, 1905) that a biochemical substrate of libido would eventually be pinpointed.

Recently, my collaborators and I carried out some studies exploring interviewer effects on anxiety and hostility. These studies, indeed, suggest that different patterns of response on interviewees can be obtained with different interviewers. The importance of such studies for psychoanalysis are that they provide some experimental means of demonstrating exactly how either countertransference or conscious attitudes of the psychoanalyst are capable of influencing the responses of the analysand. The effects of countertransference on the analytic patient are already familiar to analysts, but the more subtle mechanisms of the communication of such emotional states are not completely understood, and the extent of such effects in extra-psychoanalytic situations is not realized.

Effect of personality of interviewer on anxiety and hostility scores

Two male interviewers (actually psychoanalysts) (Gottschalk & Hambidge, 1955) each obtained two 5-minute verbal samples from eight normal, employed subjects. The first of these two verbal samples was elicited by using a so-called 'visual' method of induction (Gottschalk & Hambidge, 1955), which involved giving each subject a series of TAT cards (7 GF, 13 MF, 2 BM, 3 BM) and asking the subject to tell stories about the pictures for 5 minutes. The second verbal sample was elicited by using a standard 'verbal' method of induction in which the subjects were asked to speak for 5 minutes about any interesting or dramatic life experiences they had ever had.

The order of obtaining the verbal samples by each interviewer was balanced. That is, one interviewer elicited verbal samples first from four of the subjects and the other interviewer elicited verbal samples first from the other four subjects. Anxiety and hostility outward scores were determined from the speech samples by a technician unfamiliar with this

study. The effects of interviewer, method of induction of speech ('visual' or 'verbal'), order, and their interactions on affect scores were statistically computed (by analysis of variance). The results of this study are illustrated in Fig. 3.

ment of interviewer was unsystematic. When the verbal samples were sorted it was found that one interviewer had seen only ten subjects of each sex. So, an equal number of each sex was selected randomly from the verbal samples of the other three interviewers. These 80 verbal

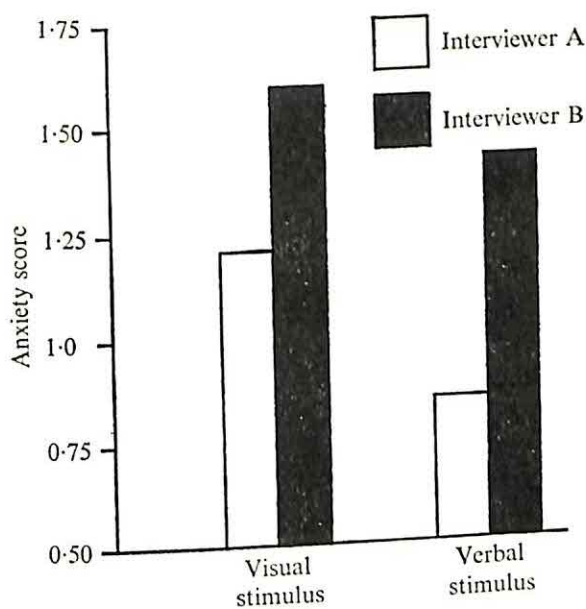


Fig. 3. Effect of two different interviewers on anxiety scores from eight subjects.

Anxiety scores were significantly lower ($P < 0.005$) when obtained by interviewer A than by interviewer B. This difference was consistent over both methods of obtaining verbal samples. No differences in hostility outward scores were noted with respect to which interviewer obtained the verbal samples.

Effect of sex and personality of interviewer on anxiety and hostility

The opportunity to look further at the effect of the sex or personality of the interviewer on the content of verbal samples was afforded by a study of 170 freshman college students, participating in pre-academic orientation exercises (Gottschalk & Gleser, 1969). These subjects, who were paid \$1.00 each to volunteer their services, all gave 5-minute verbal samples on the same day in response to standard instructions to one of four interviewers, two male and two female. The assign-

samples were scored for anxiety, hostility, male and female references, and self-references. Differences in these scores attributable to the sex or personality of the interviewer were sought statistically using what is called a mixed model, nested analysis of variance.

The average anxiety scores for male and female subjects classified according to interviewer are shown in Fig. 4. From the analysis of variance of these data it was determined that the sex of the interviewer *per se* had no effect on anxiety scores, but that some interviewers, regardless of their sex, obtained higher anxiety scores on the average than did others ($F = 3.60$; $P < 0.05$). Furthermore, some interviewers consistently obtained higher anxiety scores from female subjects; whereas for other interviewers, the higher scores were obtained with male interviewees.

The findings of hostility inward were similar to those for anxiety, as indicated in Fig. 5.

However, for this variable the interviewer effect (for a given sex) reached a higher level of significance than for anxiety.

The hostility outward scores, averaged

according to interviewer and sex of subject, are shown in Fig. 6. Again the sex of the interviewer had no significant effect on scores, but certain interviewers, regardless of sex,

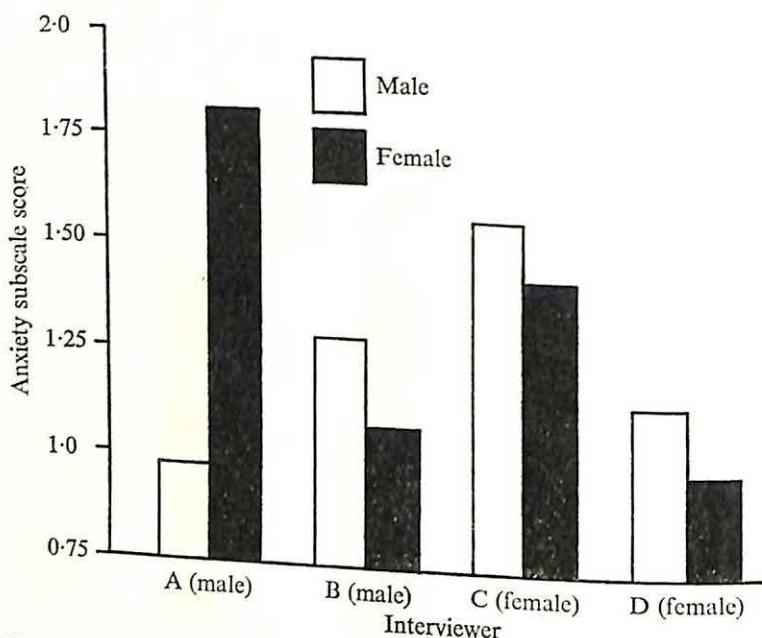


Fig. 4. Anxiety scores for male and female subjects (in groups of 10) interviewed by different interviewers.

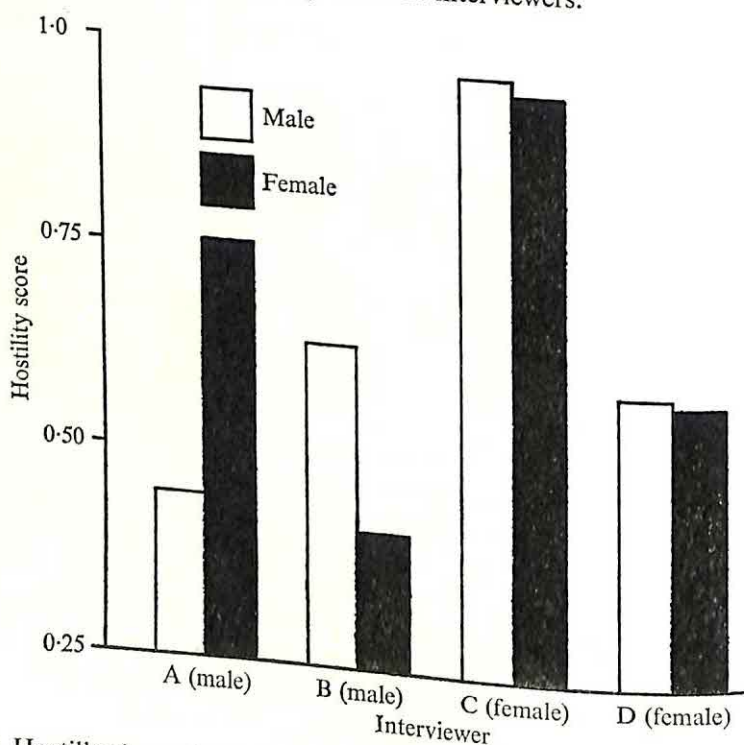


Fig. 5. Hostility inward scores for male and female subjects (in groups of 10) interviewed by different interviewers.

differed significantly in the amount of hostility outward they elicited from both male and female subjects.

jects responded with higher ambivalent hostility scores when interviewed by males than when interviewed by females. Male subjects,

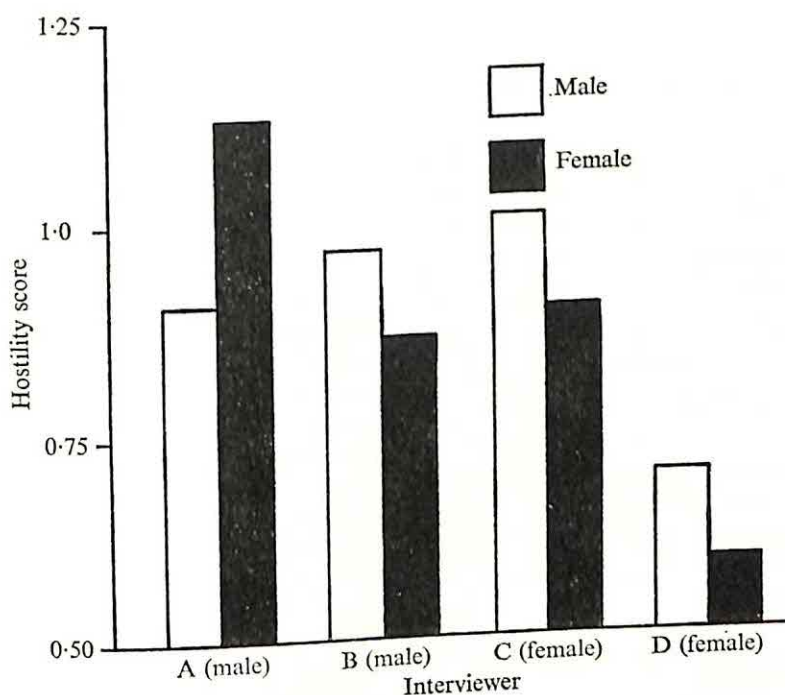


Fig. 6. Hostility outward scores for male and female subjects (in groups of 10) interviewed by different interviewers.

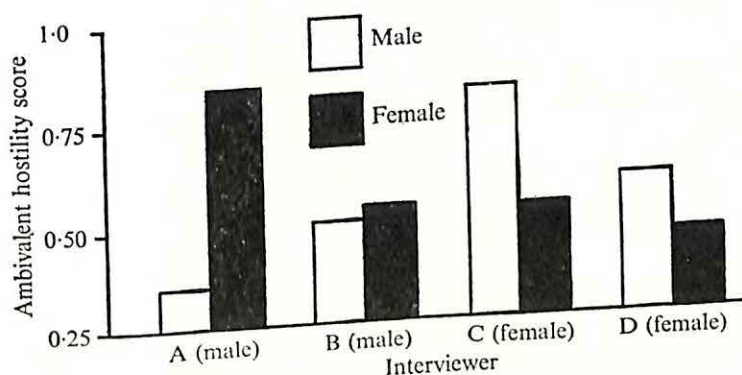


Fig. 7. Ambivalent hostility scores for male and female subjects (in groups of 10) interviewed by different interviewers.

Ambivalent hostility scores (derived from references to critical or destructive thoughts or actions of others towards self), unlike those of the other three affects, showed a definite (interaction) effect of sex of interviewer with sex of interviewee ($P < 0.001$). Female sub-

on the other hand, had higher ambivalent hostility scores when interviewed by females than when interviewed by males (see Fig. 7).

An interesting feature of these findings was that the higher hostility scores were elicited by

interviewers, a male and a female, who were in the throes of divorce proceedings, and these interviewers evoked especially high hostility scores from interviewees of the opposite sex. These interviewers were unaware of any specific feelings or behaviour on their part that might have been provocative. If either of them had been psychoanalysts, which they were not, would they have recognized their own subtle reactions to their interviewees' reactions that would help us understand why their interviewees responded in such a fashion to them? Hopefully so. But how these attitudes are communicated needs to be ascertained more precisely. Video-taping such an interview might provide some answers. It would be difficult and probably unwise to introduce a video-camera into the psychoanalytic situation, but this would be no prob-

lem whatsoever during the brief interview periods (5-10 min.) typical of my verbal behaviour research procedure.

SUMMARY

I have presented some highlights of my applied psychoanalytic research into the communication of the intensity of certain psychological states, particularly the affects of anxiety and hostility. A knowledge of psychoanalytic theory and practice provided a storehouse of guidelines about where and how to look for scientific leads of broad pertinence to the behavioural sciences and mental health. Psychoanalysis has helped develop a research method involving the measurement of feelings from language behaviour, a method that has broad applications to many problems in the medical, social and behavioural sciences as well as to psychoanalysis itself.

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Loss and bereavement as factors in agoraphobia: implications for therapy

BY PHILIP EVANS AND JOHN LIGGETT*

Agoraphobia, as well as being one of the most common of the phobias, seems also to be one of the most complex. It proves peculiarly resistant to treatment, whether by systematic desensitization, graded retraining or indeed by any other means. The ineffectiveness of direct attack on agoraphobic symptoms using behaviour therapy has been demonstrated, for example, in the well-controlled retrospective studies undertaken at the Maudsley Hospital by Cooper (1963) and Cooper *et al.* (1965), in which agoraphobics were found to have fared only slightly better than their controls, whereas improvement for 'other phobics' was significantly better than controls. In a later study Gelder & Marks (1966) showed that improvement in severe agoraphobics was no better than in controls.

Attempts have been made to explain the aetiology and maintenance of agoraphobic symptoms from the point of view of both learning theory and psychoanalytic theory. Thus Lader (1967) concluded from his work with the galvanic skin response that agoraphobics have higher levels of arousal and slower habituation rates than other phobics and that this, rather than specific traumatic learning experiences, may be responsible for symptom maintenance. Learning theorists have suggested too that symptom reinforcement is regularly supplied by the concern and companionship so freely offered to the agoraphobic by relatives and friends (Meyer & Chessner, 1970). Since agoraphobics are often extremely dependent persons, preoccupied with being stranded and left alone, such reinforcement must be expected to be especially powerful. Psychoanalytic writers have stressed

the role of relationships with loved ones, and Adler (1925), for example, has remarked on the ironic omnipotence achieved by the agoraphobic over his companions; the mountain must come to Mohammed since Mohammed is too weak to come to the mountain. Fenichel (1945) agrees with this view:

The anxiety attacks of a female patient with agoraphobia had the unconscious, definite purpose of making her appear weak and helpless to all passers by...

It is well to note the considerable regression which would be involved in achieving such omnipotence. The patient would be regarded as having regressed to a stage of very early ego development and the companion on this view would be regarded as a 'good object' (in the infantile world) over which control was complete. Melanie Klein (1960) has emphasized the hostility which is also present towards the mother, who is regarded as 'keeping things back for herself', and the consequent anxiety and guilt arising from these hostile feelings towards the 'bad object'. Helene Deutsch (1929), in her discussion of agoraphobia, underlined the ambivalence experienced towards the companion-mother, who represents not only the comforting parent but also the hated one whose presence incidentally reassures the patient that he has not killed the bad object. The agoraphobic, on this view, is a person who has never resolved these early conflicts.

It is interesting to speculate on the significance of bereavement for such patients. Bereavement might sometimes mean not only the loss of the good object but perhaps also the killing of the bad object (in the world of fantasy where the good is so often split so neatly from the bad). Other forms of loss,

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such as abandonment and rejection, might also be expected to be particularly frightening to the agoraphobic if, as dynamic theorists have suggested, he is a creature of deep unresolved dependency needs and conflicts. If these dependency needs and conflicts are indeed rooted in the very earliest experiences (and are not just products of reinforcement throughout adult life, as some learning theorists might suggest) then the agoraphobic's real fears will be diffuse and intangible, and much more than the obvious and visible fears of the front doorstep or the town centre. There will be additionally a whole complex of fears concerned with loneliness and rejection which will be much less obvious, explicit and accessible.

The purpose of the present inquiry was to explore these fears and preoccupations in agoraphobics and to try to find whether they differed significantly from those of other kinds of phobic subjects. The method employed was a projective personality test, the Liggett Faces Test (Liggett, 1957), which consists of seven poorly structured, diffused faces about which the subject is asked to make certain judgements. Previous work with 1000 normal and abnormal subjects had indicated (Liggett, 1968) that the nature of a patient's preoccupations and anxieties could be reliably elicited by asking him to declare of the faces what sort of troubles the persons represented had possibly had in the past. Responses concerned with loss and bereavement had been found to be prominent in the records of clinical and normal groups, being particularly numerous in both phobic and normal subjects. It was hoped that the present more detailed study would reveal differences in the pattern and intensity of fears between a group of agoraphobics and a group of miscellaneous phobics. In a second (or 'non-verbal') part of the Faces Test the subject was required to indicate, by the method of paired comparisons, the similarity of each face to himself. By combining the 'verbal' and 'non-verbal' results from the Test it was thus possible to find which particular troubles had been associated

with the faces seen to be most like self. The purpose of the present study was to determine whether agoraphobics would give more 'loss' and 'bereavement' responses than non-agoraphobics and whether they would identify themselves more with those faces on to which they had projected the loss and bereavement.

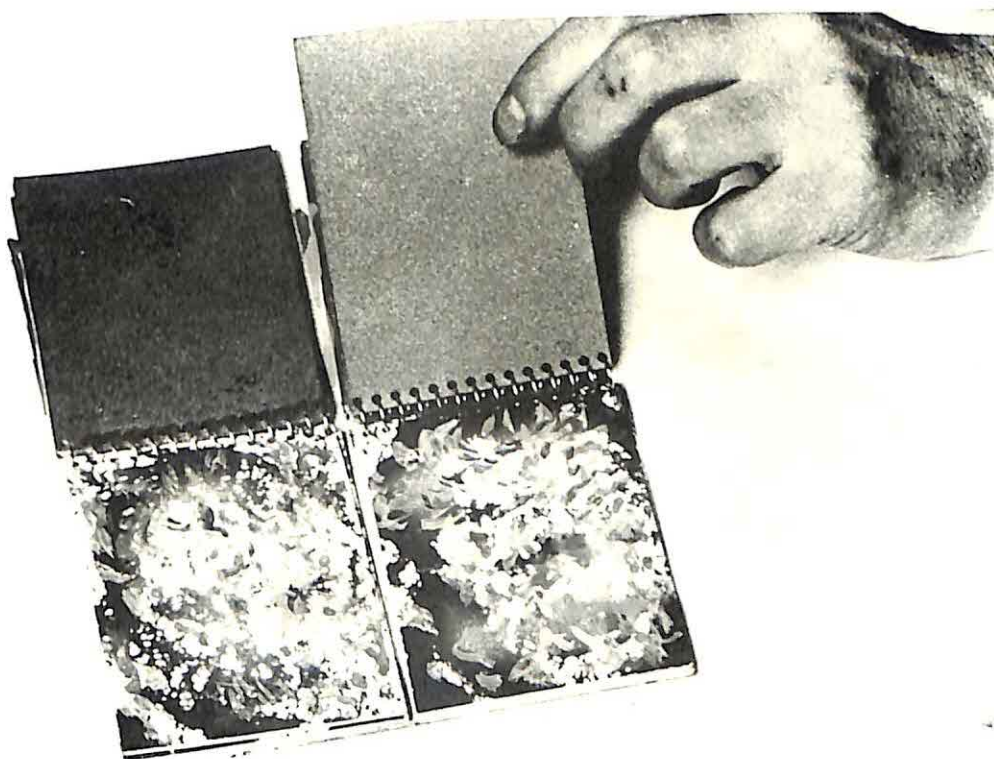
METHOD

Twenty patients, suffering from phobic anxiety were tested with the Faces Test described by Liggett (1959) prior to their receiving desensitization therapy. Ten of these patients were suffering from clearly defined agoraphobia of moderate severity not requiring hospitalization, but causing severe disruption of normal life. None were able to leave their home unless accompanied. The remaining 10 patients tested were suffering from various phobias other than agoraphobia. All patients were being treated as out-patients and were referred to the University Psychology Department from Whitchurch Hospital, Cardiff, as part of a wider inquiry into behaviour therapy.

The Faces Test consists of seven indistinct, poorly structured faces about which the subject is asked to make certain judgements. In the first (or 'non-verbal') part of the Test the seven faces were presented in paired-comparison form for ranking on various qualities. The qualities used here were: 'Which of these is probably the better person?' and secondly, 'Which of these is probably most like yourself as a person?' No elaboration of these instructions was allowed.

In the second (or 'verbal') part of the Test the subject was asked to respond individually to each separate face by answering: 'What would you expect him (her) to be like as a person?' (Either the male or female version of the Test was used as appropriate.) When responses to each face had been recorded verbatim a second question was put 'What sort of part could he (she) play in a film?' and finally 'All of these people have had trouble at one time or another; what kind of trouble might it have been?' Again, no elaboration of instructions was allowed.

Responses to the final question ('Troubles') were examined in detail and compared with the ranking judgements for the quality 'Most like self' so as to permit the following hypotheses to be examined: (1) that agoraphobics gave more



The Liggett 'Faces Test'

responses concerned with themes of 'loss' than did other phobics; (2) that they tended to attribute such loss responses to the faces they had previously seen as most like themselves, and (3) that agoraphobics showed, in particular, a special concern with 'bereavement' themes and tended to associate such bereavement responses with the faces previously seen as most like themselves.

Verbal responses of all subjects were examined and the following general categories of 'loss' were distinguished: loss of money or property, loss of status, loss of affection, physical loss (such as loss of a limb), loss of life of an (unspecified) person, loss of life of a named loved one. An attempt was made to order these varieties into a scale of severity of loss by asking five psychologists to rank them according to the amount of emotional suffering each appeared to them to entail. Four of these judges were unanimous in producing the following 'severity scale' shown in Table 1. (The fifth dissented only in that he ranked loss of affection as more severe than loss of limb.)

A score was assigned to each variety to obtain a simple ordinal scale for subsequent scoring of the verbal records. It is important to stress that no equal-interval characteristics were implied by this scale and that subsequent statistical manipulations of scores were limited to those appropriate to ordinal measurement, viz. non-parametric methods. The suitability and power of the tests used for this ordinal data are comprehensively discussed by Siegel (1956).

Table 1. *Severity of loss scale*

	Severity score
Loss of property or money explicitly stated	1
Loss of status, ambition, ideals, faith, etc., explicitly stated (i.e. all abstract concepts with personal connotations)	2
Loss of affection, companionship, explicitly stated	3
Loss of limb, physical injury of a severe kind	4
Loss of person, unnamed (Bereavement I)	5
Loss of person, named as son, parent, etc. (Bereavement II)	6

RESULTS

Table 2 shows the 'loss' scores derived from the seven statements made by each subject by applying the scoring scale to each individual response.

Using the Mann-Whitney U test the loss scores of agoraphobics were significantly higher ($U = 24$; $P < 0.05$) than the loss scores for the miscellaneous phobics.

Table 2. *Loss scores*

	Mean loss score
Agoraphobics	11.0
Miscellaneous phobics	4.5

$$U = 24. \quad n = 20. \quad P < 0.05.$$

Table 3. *Attribution of 'loss' to faces like and unlike self*

	Mean loss score	
	Agoraphobics ($n = 8^*$)	Miscellaneous phobics ($n = 6^*$)
Projected on to		
Faces like self	2.14	0.80
Faces unlike self	1.05	0.33
	$T = 4.0$	$T = 4.5$
	$P < 0.025$	n.s.

* In the Wilcoxon test, tied scores in the two conditions are eliminated, thus reducing the initial value of n .

In order to inquire whether agoraphobics tended to attribute more 'loss' to those faces seen as 'most like self' a new 'loss' score was computed for each subject for (a) the three faces declared implicitly in his ranking to be 'most like self', and (b) for the three faces declared to be 'least like self'. Table 3 shows the mean loss scores for (i) agoraphobics and for (ii) miscellaneous phobics.

The Wilcoxon matched-pairs test was used for both groups to investigate whether each patient's loss scores on the 'like self' category were significantly higher than his loss scores

on the 'unlike self' category. (For agoraphobics, $T = 4$; $n = 8$; $P < 0.025$.) For miscellaneous phobics, however, there were no significant differences between 'like self' and 'unlike self' scores ($T = 4.5$; $n = 6$; not significant). Inspection of verbal responses showed that bereavement responses were prominent in the agoraphobic records and relatively infrequent in the miscellaneous phobic records. Accordingly, a Mann-Whitney U test was employed to compare relative frequencies of bereavement responses. Table 4

bereavement responses it was necessary to compute a 'median placement' of each individual's bereavement response along the like self-unlike self continuum. For example, one patient made four bereavement responses which were attributed respectively to the first (most like self), second, third and fourth faces of his ranking. His median placement was thus midway between 2 and 3, i.e. 2.5. Median placements for the eight agoraphobics who gave bereavement responses were found to be as follows: 2.5, 2, 4.5, 2, 3, 1, 4, 4.

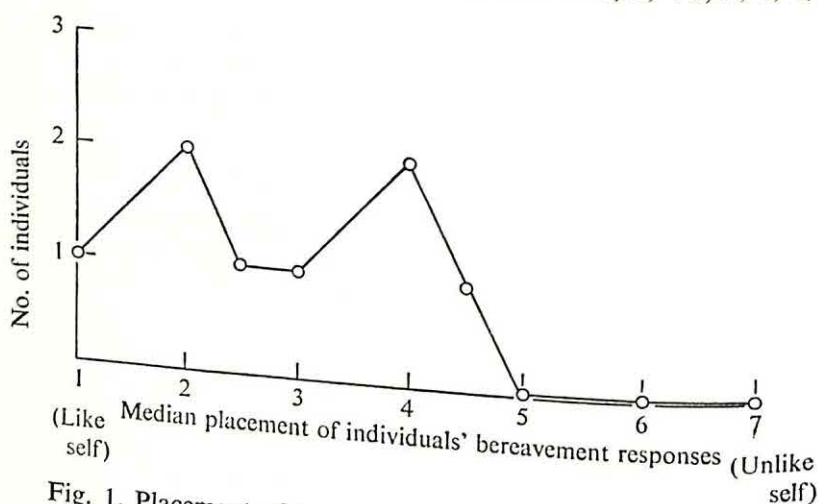


Fig. 1. Placement of bereavement responses by agoraphobics along the like self-unlike self continuum.

shows that the mean number of bereavement responses made by the agoraphobics was 1.5 (out of a possible 7) and by the miscellaneous

Table 4. Mean bereavement responses by agoraphobics and miscellaneous phobics

Agoraphobics	1.5
Miscellaneous phobics	0.3

$U = 19$. $n = 20$. $P < 0.01$.

phobics was 0.3, a difference which is significant at the 1 per cent level.

The next question to be considered was whether agoraphobics (who had already been shown to make more bereavement responses) tended to attribute such responses to the faces they had previously declared to be like themselves. Since patients gave varying numbers of

As is evident from Fig. 1, five of the agoraphobics placed their median bereavement responses within the three faces 'most like self'; two assigned bereavement to the 'neutral' face and only one case assigned bereavement within the three faces most 'unlike self'. The trend is evidently very much in the predicted direction, but the number of subjects is too small for further statistical analysis.

DISCUSSION

If we were to accept these projective test responses as indicators of genuine preoccupation we might conclude that the agoraphobics showed more concern about loss and bereavement than did the other phobics. Such a conclusion would be entirely consistent with the dynamic view of agoraphobia as a sympto-

matic condition, in which the agoraphobic features provide a means of defence against the terror of deeper anxieties concerning abandonment and rejection. On this view the anxiety of the agoraphobic would be expected to be intense and chronic since the root of his phobia is always with him; he carries it around with him, it is omnipresent. Other phobics are more fortunate in that they meet their fear situations only occasionally and can, to a degree, take avoiding action. Lader's (1967) evidence of higher arousal levels in agoraphobics provides some support for this position. On this view too it would follow that removal of agoraphobic symptoms, without regard for underlying fears, could only lead to quick relapse or alternatively to symptom substitution. Gelder & Marks (1966) have shown that such relapse is, in fact, commonplace in agoraphobics treated by behaviour therapy, almost all their cases reviewed having relapsed after one year. Though symptom substitution is a concept sometimes difficult to defend on strictly logical grounds since it may lead to an infinite regress, its occurrence in particular cases must surely be considered a possibility.

If symptom removal is unsatisfactory, what then must be the therapeutic strategy? What kind of relearning experience is needed to remove the underlying fears? Perhaps the first requirement is that the patient should be allowed to feel his true fears and to recognize their true source. If these fears are to be diminished he must be allowed to test them against reality. Such requirements can be met and adequately monitored only in the context of a warm therapeutic relationship. There is abundant evidence for the effectiveness of therapeutic relationships involving empathy, warmth and genuineness (e.g. Truax & Carkhuff, 1967). The necessary prerequisites for such effective therapeutic relationships have been discussed by Rogers (1957). Of all therapeutic situations, however, those invol-

ving agoraphobics must be expected by the therapist to be the most demanding, difficult and patience-testing. It is in the nature of the agoraphobic's disorder that he must constantly test, challenge and assault the relationship, waiting for it to collapse into the expected experience of loss and despair. The therapist is the embodiment of society's unreliable face; he must be tested and proved to be the harsh rejector he really is. But every time the test fails, we may expect a decrease in fears of rejection and abandonment. The therapist, following established learning principles, must maximize the opportunities for such testing, so that the unlearning of fear may be swift, permanent and complete.

Here perhaps is to be found a meeting-point for behaviour therapy and more orthodox psychotherapy. Behaviour therapists have freely admitted that it is only when the real fears of the patient are tackled that behaviour therapy can be successful. And as orthodox therapists have so often declared, such fears can be elicited, approached and annihilated only in the context of a warm therapeutic relationship.

SUMMARY

The Liggett 'Faces Test' was administered to a selection of phobic patients to assess their fears and preoccupations immediately prior to their receiving behaviour therapy. Agoraphobics were shown to differ significantly from the rest of the phobics in the greater amount of loss and bereavement projected on to the obscured faces. The agoraphobics tended to project this loss and bereavement on to those faces previously ranked as most like themselves. Results are discussed with reference to the literature on agoraphobia and to their possible relevance in the field of therapy.

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Children with surrogate parents: cases seen in analytic therapy and an aetiological hypothesis

BY A. C. REEVES*

The purpose of the present paper is to offer a clinical contribution to the understanding of some specific noxae which may follow for the child on the substitution, at or around the time of birth, of the natural mother by a surrogate who is entrusted with the future rearing of the child. In two of the cases I shall be considering, the children were adopted and in the third the child was fostered. For the purposes of the present paper I shall prescind from the social and legal differences between fostering and adoption, not because I believe such differences to be irrelevant in themselves, or of little consequence to the mother and child, but because their implications, and the manner in which these impinge on the mother-child relationship, assume significance at a stage somewhat later in the development of the relationship than that which it will be the business of the present paper to explore. Furthermore, as I hope to show, the difficulties encountered in establishing healthy object relations for such children, whether fostered or adopted, are more specific, and have more in common with each other, than those encountered by the ordinary infant reared in his own family, on the one hand, and by infants brought up in an institutional setting or by a succession of caring figures, on the other. For these reasons, I shall refer to foster and adopted children indifferently as 'children with surrogate mothers'.

The importance of satisfactory early mothering for the healthy mental and physical development of the child is accepted almost as axiomatic by present-day clinicians and research scientists. There is general agreement

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that in the first months of life the infant does not possess and has yet to acquire 'a solidly established, dependably functioning ego organization' (Spitz, 1965). Much observation has been done on earliest mother-child interaction and its implications for future development (Bowlby, 1951, 1969; Winnicott, 1958; Spitz, 1965). Psychoanalytic theory, especially that deriving from clinical work with young children, has also made a significant contribution to the understanding of infantile behaviour (A. Freud, 1936, 1965; Klein, 1932, 1948). Attention has been paid to the pathogenic consequences of loss of the maternal figure (Bowlby, 1953, 1960, 1963; Burlingham & Freud, 1944; Robertson, 1953) and to the failure of adequate maternal provision during infancy and early childhood (Spitz, 1965; Mahler, 1968; James, 1960; Tustin, 1969). Much of this work is well known and has significantly influenced public attitudes and practice in such matters as the quality of institutional provision for children separated from their families, hospital care for the very young, and a variety of child-rearing practices.

In comparison, the literature dealing specifically with the problem of children with surrogate mothers is meagre, and its implications not widely accepted. The view of the Curtis Report (1946) continues to inform much public thinking in the matter of provision for children who cannot or will not be brought up by their natural parents, namely that adoption is 'the most completely satisfactory method of providing a substitute home'. The report further states that 'there is no statistical evidence of the percentage of happy results, but in the absence of evidence to the contrary it is reasonable to suppose that

in the large majority of cases the connection turns out well'. A body of evidence has accrued since the report was published to call in question the correctness of the committee's opinion, without, however, affecting in any appreciable way either conviction or practice in the matter of adoption.

The high incidence of psychological disturbance in children reared by foster or adoptive parents has been noted by a number of workers (Humphrey & Ounsted, 1963, 1964; Schechter *et al.*, 1964; Goodman *et al.*, 1963). An intensive study was conducted by McWhinnie (1967) into the history of a sample of adults who had been brought up as adopted or foster children. Her study is valuable in giving lengthy case histories based on interviews, together with an assessment of the degree of adaptation they displayed as adults. The results of her study do not support the view that the problems of relationship for foster or adoptive children are no greater than those potentially inherent in any parent-child relationship. Of the 52 cases comprising her study sample, 15 were rated as having a reasonably good adjustment in all areas at the time of interview; six were judged as having dealt successfully with problems relating to adoption; 10 were at the stage of becoming partially free as they gained in confidence and independence; 11 were still tied in one way or another to the problems of their adoption or upbringing; and 10 were judged as being poorly or abnormally adjusted in many areas. Moreover, her study showed that the incidence of maladjustment did not correlate significantly with such particular factors as the age of the adoptive parents, the age at which the child was adopted, or whether, and at what age, the child was informed of his adoptive status. It appeared that the fact of adoption was itself a principal factor in the incidence of maladjustment. This conclusion was shared by Jackson (1968), who studied 40 cases of adopted children referred to a child guidance clinic. Both she and McWhinnie found that the parents of unsuccessfully adopted children themselves

showed a high degree of instability, a fact alluded to in several other reports.

Some writers have attended to the particular problems of adopted children (Eiduson & Livermore, 1953; Frisk, 1964). Sants (1964) has stressed the relevance of uncertainty concerning their origins to the understanding of their behaviour. He has termed this factor 'genealogical bewilderment'. Toussieng (1962) has suggested that the greater proneness of adopted children to emotional disturbance can be attributed in part to the difficulties of the adoptive parents in regard to parenthood.

Notably absent from the literature are any detailed case reports of children with surrogate mothers who were seen in analytic therapy, or any major contribution from psychoanalytic theory towards the understanding of the specific difficulties faced by the child and the surrogate mother. Winnicott (1954*a*) offers a brief but valuable study of two children who were both adopted by the same parents, with differing outcomes. He goes on to make some sensible suggestions concerning adoption placement and the importance of the correct timing of placement.

What is lacking in the body of literature relating to children with surrogate parents, it seems to me, is not prescriptive pronouncements or statistical documentation of success and failure, but descriptive studies from direct observation or from reconstruction through the therapeutic situation of the earliest interactive processes of the child and the mother which are crucial for the understanding of the future outcome of the relationship. It is hoped that the present paper will offer a small beginning towards remedying this deficiency, at least in regard to the second aspect, as well as suggesting some lines of further study and observations. I shall first present a brief summary of the three cases, before discussing some of the qualitative features of the interaction between patients and therapist. I shall then attempt to relate these features to significant events and sequences in the parent-child relationship as these were learnt from the parents' report at

the time of the referral, or as they emerged from case work interviews by the social worker with the parents in the course of the treatment. Finally I shall tentatively propose a dynamic hypothesis to account for the observed phenomena in relation to a specific aetiology of the child-surrogate-mother relationship.

Of course, the evidential value of data and hypotheses resulting from such a procedure may be called in question. In the first place, it is clear that what is being proposed is simply a hypothesis whose value and limits remain to be established. Secondly, it is inherent in my thesis that the processes of interaction between patient and therapist as they unfold within the particular framework of the analytic setting can be apodeictic, not only of the present disturbances in the manner of the patient's and family's object-relating, but also of the earliest deficiencies from which the present disturbances arise. I am aware that this statement implies a conception of the therapeutic action of psychoanalysis which is the object of divergent opinions. However, it is not the function of what is intended as a clinical contribution to enter into an extensive discussion of first principles. It must suffice, for those wishing to pursue the epistemology, to refer to Freud's discussion of the place of 'constructions' in analysis (Freud, 1937), and to Loewald's magisterial paper on the therapeutic action of psychoanalysis (Loewald, 1960). Heimann's (1950) paper on counter-transference is likewise relevant. The literature on this vexed topic is reviewed by Orr (1954). For the rest, I would merely echo the view expressed by Khan (1964):

It is my clinical experience, and it has been that of others as well, that when we have the material from a patient that relates essentially to his ego distortions from cumulative trauma, then it is the analytic setting and the patient's relation to it that becomes of imperative clinical and transference importance... The patient repeats with acute finesse and minute detail all the elements of the primary infantile situation. This indeed is repetition in the concrete, as it were... When we watch

the patient's reactions and behaviour over a period of time and are not impatient of his attempts to bring us under his omnipotence, then we can observe with fair accuracy in what manner he cannot tolerate certain things and how his ego distorts the situation in order to avoid those areas of stress with which his ego defect cannot cope.

CASE HISTORIES

Case 1. Jane, aged 4, was referred for persistent soiling, and secondarily, for marked aggressive behaviour towards her younger sibling, Sophie (2 years). Both children had been adopted at 6 weeks.

The parents had been married for 4 years prior to adopting Jane. They had married in their mid-30s. Mother had previously been married for a brief period to a man whom she left and subsequently divorced on account of his homosexual practices. There were no children by either marriage. Both parents appeared to be extremely lacking in confidence, defensive, anxious in their handling of both children, and vulnerable to the strictures, real or imagined, of relatives and neighbours.

On referral Jane was a dishevelled, drawn, unhappy little girl, whose nappies bulging from beneath her skirt seemed to proclaim to the world the abjectness of her condition. Toilet training was first attempted at 12 months, on the day that she had been given an injection. She had screamed on being made to sit on the pot, and though the parents did not persist at the time, all subsequent attempts at toilet training were unavailing, despite all manner of parental pressure. Similar difficulties were not experienced with the younger Sophie, and Jane was made aware of the unfavourable comparison. Jane's soiling and general messiness had alienated her from playmates. Although the parents expressed doubts initially about Jane's mental and physical endowment it was soon apparent that she was a bright, alert girl of superior intelligence.

Full analytic therapy (five times weekly) was undertaken and has been in progress for 9 months at the time of writing. The soiling stopped after about 6 weeks of treatment. This was preceded by a brief period of soiling during the analytic sessions. The initial phase of treatment was marked by silence, tentativeness, absence of movement. After a few weeks she began to explore the

contents of her toy box, then the room, and finally the therapist. A period of shared play followed, though she was still mute, before a bout of soiling in the sessions, followed by messy play with plasticine and water, led up to the start of verbal communication with the therapist. Verbal communication and drawing have been her principal activities since then, interspersed with water activities, usually 'washing' or 'making tea'. Treatment continues.

Case 2. Stephanie was 10 years old on referral. An attractive dark-skinned girl, she was the illegitimate child of an Irish mother and Indian father. Soon after birth she was placed in a private children's home, where she exasperated the staff through her refusal to eat. She was befriended by one of the staff, however: a young woman who concerned herself especially with her, and who maintained contact after leaving the establishment. Stephanie's mother took her back to live with her for a time, but, having decided to marry, she preferred to be without her illegitimate daughter, and the young worker who had formerly interested herself in Stephanie was given her to foster. The foster mother was unmarried, and had herself been fostered as a child.

Apart from prolonged bouts of stubbornness, the foster mother reported no special difficulties with Stephanie. Problems, however, were reported by the school. These primarily concerned stealing, although there were sexual misdemeanours too. Stephanie, who was otherwise regarded as a meek and compliant child, at first persistently denied being responsible for the thefts (smallish amounts of money removed from other girls' pockets). When she admitted to them, she was extremely concerned that her foster mother should not know about the trouble. Disavowal, accompanied by acute anxiety at the suggestion of the mildest criticism, was a manifest feature of her behaviour. Underlying this were intense fears of rejection which were constantly lent substance. Thus, at the time of referral, there was a general concern, never quite verified, that the school was about to expel her, though they were very sorry for this 'orphan girl'. Beneath this, as a further layer, and largely inaccessible to her for the first 18 months of therapy, were her own active feelings of ambivalence towards her primary figures.

Therapy, which continued for $2\frac{1}{2}$ years of once-weekly sessions, fell broadly into three phases, which largely reflected the threefold

layering of manifest disavowal, fear of rejection which was denied but barely repressed, and deeply repressed ambivalence in active object-relating. The drawn, timid, little girl on the start of treatment became an actively attracting, sometimes flirtatious, often provocative adolescent by the time treatment was terminated. Some of the flavour of the ongoing process of therapy, and its characteristic vicissitudes, should become apparent in the discussion below.

Case 3. Paul was 11 years old at the time of referral. He was the younger of two adopted children. Like his sister Catherine (15), he had been adopted at 7 weeks by his present parents, a comfortably organized middle-class couple who had married in their mid-30s and had decided on adoption when the father was found to be physically impotent. Catherine's adoption had taken place early in marriage, followed by Paul's 4 years later.

Paul had been born by caesarian section, an illegitimate child, and fostered for the first six weeks. His adoption had not been a straightforward matter, as the Adoption Society doctor was not happy with Paul's physical condition. (Mother reported that he 'looked transparent'.) The upshot was that he was placed with the adoptive parents, then, within a few days, returned to the foster mother, while further medical examinations were carried out, before going finally back to the adoptive parents.

According to the parents' report, difficulties in the early stages of development centred on three areas - feeding, speech, and separating from mother. Though he took well to the bottle, he refused solids and continued subsequently to be extremely selective in what he would eat, confining himself to a diet of cereals, cheese, fish-fingers, peas and potatoes.

His speech was late in developing and remained retarded and idiosyncratic. His parents said he talked 'gibberish' when he went to nursery school. He was seen by two speech therapists, without any noticeable improvement occurring. At 5-6, however, his speech became more intelligible, though he was still extremely hesitant at the time of referral. On testing, he was found to be of superior intelligence.

The major difficulty from the parents' viewpoint concerned his inability to separate from mother. He was apparently amenable until months, after which he screamed whenever

mother left the room. When admitted to hospital at 4 years he was forcibly dragged from his parents at the end of visiting times, and two or three nurses were used to give him medicine. He was discharged early because he was so unmanageable. When he started school there was a repetition of the forced separation – Paul clinging to mother and being held by the teacher. This gave place eventually to a prolonged ritual of goodbyes, kisses, followed by a return and more goodbyes.

Some months before his referral further debilitating symptoms began to occur. He would never throw any rubbish away, and would not let the parents throw anything away. Each evening he would go through the dustbin to see what mother had thrown away during the daytime, sometimes rescuing packages and other contents of the dustbin. He also developed a touching ritual. He would say to mother, 'Be careful not to touch anybody'. If she touched somebody, even accidentally in passing, he would have to go back and touch them also. He was concerned about his 'Irish blood'. (His parents had informed him very early that his natural mother had been Irish.) He would ask: 'Can I get rid of it?'

Both parents appeared to be extremely hostile towards Paul. Mother felt that whatever love she once had for Paul had been drained out of her by his demanding and unreasonable behaviour. They wavered between seeing his behaviour as a wilful exercise of destruction or as an expression of madness. They had frequently threatened to send him back to where he came from.

Treatment for Paul continued with interruptions for about 6 months, when it was discontinued through the parents' inability to get him to the clinic. For the first few months Paul came willingly enough, provided he could arrive on his bicycle before his mother, who would follow on foot a couple of minutes after. During this time the obsessional symptoms disappeared, but there was an increase in overtly physical and verbal aggressive behaviour towards the parents. After the summer break Paul went to the grammar school. Thenceforward he would not attend, and the parents found it impossible to bring him. At the time of treatment he would leave the house and disappear, sometimes going into the woods, and at other times going round the house of his former head-teacher, with whom he was very friendly. Mother continued to have interviews with the social worker.

DISCUSSION

Despite their differences in age, sex, circumstances and symptomatology, these three children manifested some strikingly similar features in their therapeutic interaction with me. Indeed, it was the similarity in their manifest behaviour, together with the fact that they were all three being reared by surrogate parents, that prompted me to study the phenomenology more closely. In the discussion I shall follow as closely as possible the stages of my actual evaluation, beginning with a description of some characteristics of the manifest behaviour of the patients, followed by an account of the pattern of felt response in the therapist, and some of the vicissitudes, practical as well as theoretical, which were encountered. I shall then attempt to relate these treatment experiences re-constructively to significant moments of object-relating, historic and current, particularly in relation to child and surrogate mother.

In the first place, all three children displayed a marked passivity in therapy, especially during the initial phases. During the 5 months of weekly sessions with Paul, he uttered no more than five or six sentences, and these usually in response to some prompting on my part. Similarly, Stephanie remained almost totally mute throughout the first year of weekly treatment. In the early stages she would stand near the door on entering my room, her hat and coat still on, with every appearance of being ready to stand there motionless for the whole hour. On one occasion she let a fly crawl up her hand and arm for several minutes without making any attempt to brush it off. Jane, too, would stand motionless and silent during the early phases of treatment, peering at me and at the walls of the room, occasionally scratching a scab on her face or hand, or else placing one foot on top of the other, but permitting herself no further liberty of action save in response to a movement or gesture of mine.

In none of these cases, however, did I form

the impression that this remarkable, uncanny and thoroughly disconcerting passivity betokened an active demonstration of withdrawal or negativism towards therapy. Of course, their passivity was compounded of several different elements, among them doubt, suspicion, a conviction that treatment was a punishment inflicted by the parents, and a fear of being taken away. Such elements, or combinations of some of them, are present in almost every child who is brought by his parents for treatment. None of these, however, seemed to be the primary determinants of these children's passivity. If they were prisoners, they were not recalcitrant; if they were separated, they were not rushing in search of mother, or clinging desperately to her in the waiting room. Rather, what seemed uppermost was an attitude of *generalized acquiescence*: it was as though they felt as if they had 'made themselves over' to me, or had been 'given over' by the parents. In the former case, they would be alert, listening, peering, alive to every gesture, word, or inflexion of mine: in the latter, they were withdrawn, expressionless and inaccessible. One or other of these features could predominate in the same child, either between sessions or sometimes within a single session. In either case the passivity remained.

The particular difficulty encountered by these children at the start of treatment appeared to derive from a propensity to concur. That is to say, they seemed to be incapable of initiating any exchange, either verbally, in play or by motor activity, unless a clear indication was forthcoming from the therapist that such an action was required or invited. Spontaneous autonomous behaviour appeared to be beyond their capacity at this stage. This incapacity revealed at the outset a hiatus between the expectations of patient and therapist. It is an accepted norm of analytic therapy that the therapist *responds* to the patient, by accepting, understanding and interpreting what he brings to the therapeutic situation. The child in treatment talks or plays or draws, and thereby implicitly accepts

that what he does is matter for the therapist. When, as a defensive response, the child either temporarily or permanently abrogates the contract, then a form of negative therapeutic reaction occurs, which is exhibited in withdrawal, refusal to attend or a variety of forms of acting out, either within the session or outside. With the present children, however, the contract that the patient initiates activity, to which the therapist responds, appeared to present inordinate difficulty. None of them exhibited marked psychotic features, or functional disorders, such as to render them incapable of comprehending the therapeutic situation or of adjusting to its parameters. What they did seem incapable of, however, to varying degrees and for varying lengths of time, was to function as agents in the analytic setting, by providing there some explicit self-disclosure, to which the therapist could respond by interpretation.

Faced with this hiatus, one principal communication access from the patient remained, namely that mediated by the therapist's own reactivity as a feeling person, and registered in his own countertransference feeling responses. The actual quality of this response is difficult to convey with precision. The main feeling 'tone' of many of these sessions was a mixture of intimacy and disorientation. At times I would have the experience of incredible closeness, as if I could intuitively comprehend the significance of the slightest detail of gesture or behaviour; and at other times, and occasionally with surprising suddenness, a contrary experience of remoteness, when I began to wonder whether my interpretation of the moment before were merely a soliloquy, empty of reference, and unheeded by the patient. It was like the experience of being engulfed with another person in a blanket of fog: for the most part the other is lost to view, then the mist lifts for a moment and there is recognition and reassurance, only to be lost again. In such circumstances the absence of vision seems to enhance the threshold of sound; verbal communication takes on a particular resonance. In the present

case, the absence of verbal communication from the patient seemed to enhance the threshold of non-verbal, primary process communication, the language of the 'third ear' (Reik, 1949).

I also became aware, as I grew more accustomed to the silence, and attentive to what was being communicated through it by the patient, that, at certain times, in making an interpretation, I was genuinely seeking to convey the significance of the patient's way of acting to him, whereas at other times I was bent on evoking a reaction in the patient in order to get him to abandon his passivity because either the degree of 'merging' or the sense of disorientation was at that moment felt as unendurable. Unfortunately, I find it impossible to illustrate the moments of convergence, when I sensed with some satisfaction that I was in tune with the patient and conveying a meaningful interpretation which could articulate an experience for him. Of their very nature, such interpretations, drawing so largely on the momentary registration of feeling in the therapist, and structured round the minutiae of fleeting symptomatic acts, are transitory and labile, and resist the efforts to recall and validate after the event. The moments of divergence are better preserved, for they are often registered in palpable mistakes. I shall give an example of one sort of parapraxis which seemed to me on subsequent reflexion to indicate an unconscious reaction on my part to a degree of fusion with the patient which was experienced as intolerable.

On two occasions, once with Stephanie and once with Paul, I found that whilst giving an interpretation, I addressed the child by the name of another of my patients. My initial reaction to this parapraxis was, understandably, a mixture of distress and embarrassment. I did not, however, experience an immediate urge to offer an apology or engage in some compensatory activity. I was struck by the relative absence of feelings of concern. What I did register was that the misnaming was somehow a product of the

ongoing situation with the child, which it was my business to try to understand.

There were a number of interesting features about this particular parapraxis. In the first place, there was on both occasions a delay between making the mistake and realizing that I had done so. It was only after I had finished speaking that it dawned on me that I had used the wrong name. Furthermore, either the child did not react to the misidentification, or at least not in such a way as to make me aware of what had happened. I was conscious of having discovered the mistake for myself, and my first reaction was to wonder whether the child had noticed, and next to wonder whether I had, in fact, used the wrong name, or simply thought I had. Though I am reporting two distinct events, with two different patients, and separated by an interval of more than a year, the circumstances were so similar, and my reaction to them so alike, that I find it now almost natural to elide them.

I earlier characterized the feeling tone of many of the early sessions with these patients as a mixture of merging and disorientation. There were moments experienced as intimate convergence, followed by others of imperceptive divergence. I certainly felt 'divergent' from the patient when I discovered that I had used the wrong name. At the moment before, however, in the process of observation and understanding that led up to making the interpretation, and even at the time of making it, I had felt 'convergent' on the patient, 'in touch' with him. It was as if I were reacting to something particular in the patient's mode of functioning, and to the response this evoked in me. When I examined the names of the children whom I had unconsciously substituted, I found that the matching revealed a 'wish fulfilment', for in each case I had introduced the name of another patient, similar in age, sex, and even general appearance, but differing significantly from the patient in giving evidence of a much more solidly established ego structure. They were children whom I could not imagine myself

misidentifying, as I had these two patients. I concluded that it was the relative absence of appropriate secondary process functioning in the child which I was reacting to in the moments of 'divergence'. My unconscious reaction to the inner confusion of 'not knowing where I was' with the patient, was to substitute for the patient's unidentifiability the ready identity and secure personality contours of another, a 'proper' patient, one who did not involve me in these mysterious confusions, with their distressing, elusive, unacknowledged ambiguities. And then, for the first time, I felt that I was beginning to understand the plight of the surrogate mother, who had remarked with a mixture of despair and vehemence that 'if he had been my own child, he would never have been like this'.

The conviction that by this parapraxis I was being introduced to a specific pathogenic focus in the relationship between surrogate mother and child was strengthened by two further factors. In the first place, these two instances of addressing a child patient by the wrong name were almost identical in their circumstantial detail, before, during and immediately after the event. And the only other instance in which a child has actually believed that I had misnamed him, by mishearing 'poor' for 'Paul', occurred with another child with surrogate parents whom I later saw in treatment.

The example I have so far considered demonstrated a sudden disruption, or divergence, of an otherwise seemingly satisfactory ongoing process of empathic convergence on the part of the therapist. In describing the event I have deliberately left the patient's response to it shadowy. I described how, at the time, the patient seemed to give no indication of awareness that I had misnamed him, though my absence of felt concern led me to suppose that the parapraxis was more an epiphenomenon of the peculiar transference relationship than an indication of a damaging transference on to the patient of conflict elements from my own object relationships. What was clear,

however, was that the parapraxis, whatever its roots in the transference relationship with the patient, was the act of the therapist. I now wish to consider some similar disruptions of periods of empathic convergence which arose out of a sudden action or intervention of the patient.

Stephanie, after a year of silent withdrawal, when she had sometimes appeared too timid to sit down or to take off her coat, began a new session by suddenly offering me a sweet. I was startled by this totally unexpected gesture, which seemed so at variance with the behaviour which had preceded. In looking back over the sessions leading up to it, I could discern no thread of development, no gradual evolution, which would have made this new initiative foreseeable. This gesture, indeed, marked a turning-point in her relationship to me in the treatment. In place of the diffident, withdrawn little girl, there emerged within a brief span of time a determined, coquettish young lady. She became the dominant partner, bent on gauging and controlling my feelings. Often she would say 'You are in a bad mood' or 'I can always tell when you're angry from the way you sit'. And I discovered to my amazement and chagrin, not so much that she was right, as that by saying it she, as it were, *made* it right: I did perceive that I felt in a bad mood, or angry, after she had said it. It took me a long time to realize that by acting in this way she was reversing the roles in a very direct and concrete way, and allowing me to experience the effect on her of my verbalizations of her moods and feelings from my reaction to them, during the long periods of silence which had occupied so much of the first year of treatment. I discovered that this 'generalized acquiescence', which was the outstanding feature of the early behaviour of these patients in treatment, extended beyond an external manner of relating: the effect of my interpretations had been not simply to articulate feelings already formed and fashioned in Stephanie, but, by the very act of verbalizing them and rendering them conscious, to cue,

and in a manner condition, what she consciously experienced. In other words, she had been unable to accept and internalize her own repressed feeling states otherwise than as introjections of the therapist. I shall return to this point and examine its significance in relation to the ego state it subsumes in the subsequent theoretical discussion.

Another example of sudden disengagement from an attitude of affective and behavioural passivity was manifested by a twice-repeated occurrence in Paul. He would regularly bring a book to the sessions. When I met him in the waiting room he would immediately go on ahead of me to the room at great speed, and would normally be sitting in 'his' chair by the time I had arrived. Already his head would be buried between his knees, where it would remain, except for intermittent upward exploratory glances from the under-cover of his hair. Sometimes he would wait a little while before opening the book; at other times he appeared to engross himself in it immediately. I say 'appeared to engross' for I felt that he was far from being involved in the contents of the book. It seemed to serve more as a 'barrier against stimuli' than as a diversion. Perhaps because of this, I did not register a sustained feeling of frustration at a forcible exclusion. Rather, I felt that Paul was making a necessary accommodation in the way in which he could accept and assimilate my presence, somewhat as Stephanie had done at a similar stage in treatment by keeping her outdoor coat firmly buttoned up throughout the session. The book, it seemed, would form a bridge between me and him: it was as if he could only accept my presence and interpretations by picking them up from the open pages of the book. Such, in general, was Paul's habitual mode of relating. No confirmation, disagreement, resistance, was expressed to what I might say. The only times he would physically react to anything spoken was when I told him that it was the end of the session, at which he would abruptly close the book and depart as hastily as he had come in. On two occasions, however, he did interject, in a quite

puzzling manner. I had interpreted his fear of active engagement with me, pointing to his need always to bring a book to his sessions. Suddenly he said: 'You've forgotten something'. I asked him to tell me what I had forgotten, but no further elucidation was offered. The effect of this remark, appearing out of context and unelaborated, was certainly baffling: whereas, only the moment before, I had felt sufficiently in touch with him to essay an interpretation which did not simply verbalize his ongoing behaviour, but linked it with what I felt to be its roots in infancy, I now felt out of stride and lost. On the one hand, there were countless things that I was unaware of, or I had overlooked or misunderstood. But forgotten? This seemed to imply that there was something I did, or should know, and had put out of mind. Not infrequently a child will say, 'You don't know what you are talking about' or 'You've got it all wrong.' A child, in thus rejecting an interpretation, is often conveying that his perception does not correspond to your interpretation or, in other words, that his conscious awareness has not hitherto been, and still resists being, in touch with the repressed unconscious (Freud, 1925). But the resistance is not confined simply to the unwillingness to accept a fragment of the repressed unconscious; it stems also from the need to affirm the inviolability and integrity of the child's own consciousness, which has been called in question by the therapist's capacity to communicate with the unconscious core of the patient. Speaking familiarly, one could paraphrase this common response of the child thus: 'You don't know what it is you are talking about; you didn't have the experience of it; you aren't me; *you* never will be able to become *me*.'

Paul's statement, however, seemed to suggest something different: that I should have been more in touch, I should have known, remembered, and that what I had said, or failed to say, was evidence to the contrary, a matter not for reassurance on his part, as with other children, but a cause for

disappointment. But the effect of Paul's abrupt remark was more revealing than its content. Like one of King Henry's hapless wives, whose failure to satisfy the monarch caused them not merely to be excluded from the royal bedchamber but to lose their heads as well, I felt the full impact of sovereign disapproval.

In the case of Jane, the switch from affective dependence to affective dominance was likewise apparent, though the transformation was more gradual. In the period of transition from silent play to communication in speech, she evolved a ritual which she regularly practised with me. Taking the ruler from her toy box she would lay it on the table and point to the number 1, giving me to understand that she wished me to utter the appropriate numbers as she moved her finger up the ruler's edge. This exercise was repeated several times. At first, this piece of play seemed to offer her a compromise between her wish to speak and her fear of making any utterance. (It will be recalled that Jane's difficulty on referral was to do with soiling.) In a certain sense I had to lend her my voice. Gradually, however, I sensed that this 'need' assumed a different character with the constant repetition of the exercise. What appeared to begin as a need for an auxiliary in her functioning, emerged as a compulsion to control my vocal organs and harness them to utter for her. This was apparent from her behaviour when I did not respond: she became imperious, waving the ruler up and down, in play threatening to smack my hand as though I were a naughty child and she a harsh, demanding parent.

THEORETICAL CONSIDERATIONS

These several examples illustrate in a concrete and describable way a process of interaction between patient and therapist which was experienced repeatedly in different forms especially during the early phases of treatment. Schematically, one could represent the process as comprising three phases. (i) A

period of interaction which I have described, in terms of the therapist's feeling response, as one of relatively sustained 'empathic convergence' on the unconscious, primary process of the patient. (I am aware that such a description is somewhat bald, and liable to misinterpretation. Suffice it to say, that it is intended to denote the experience of 'being in touch with' the patient, and the recognition that the patient, for his part, is also 'in touch' with his own feeling state and with the 'presence' of the therapist whose access to those feeling states has made them 'present' for him.) (ii) The reaction: a sudden intervention, emanating from an act of patient or therapist, which in a moment destroys the previous state and appears, at its occurrence, totally discordant with what had gone before. (iii) The sequel: an internal realignment of both partners, who now experience each other as distinct and perhaps even alien. It is at this point that I as the therapist felt most a prey to self-remonstrances of the sort: 'You were deluding yourself, if you ever presumed to believe that you could have access to the patient's inner experiences, and hope to make them intelligible for him. Why, he has never told you anything; he has never really indicated that you were on the right lines. You were merely soliloquizing with a fantasy representation of the patient, the child as you imagine him to be, not as he really is. And haven't you only confirmed this by blurting out the wrong name? You know, and he knows, that you are not really treating him, but an imaginary patient you have substituted for him.' Such strictures are nothing but an expression of *disillusionment*. As such, they form the key link in relating what has passed in the transference between patient and therapist with the significant dynamics of the child and his surrogate parents.

What was striking, and even alarming, on first interview with the parents of these children was the detached, almost brutal way in which they would describe the child. They appeared to be determinedly insensitive to the child. His behaviour was described as

inexplicably discordant with the expected pattern. They could not comprehend how the child, hitherto compliant, docile, good, had suddenly developed a pattern of behaviour which was messy, naughty, tiresome, and unamenable to correction by the normal constraints of parental control. It was noteworthy how frequently an accent of exasperation crept into the account of their dealings with the child. Questions like: 'Is my child mad?' were not uncommon, and attributions of the child's failure to comply with parental demands to characteristics inherited from the natural parents were also frequent.

What the parents are here expressing is the disenchantment which follows the breaking of what Winnicott (1945) has called the 'area of illusion'. In the discussion which follows I shall be drawing freely from his extensive explorations of the linked concepts of 'integration', 'illusion', 'dissociation' and 'disavowal'.

In the first place, it was clear that the symptom formation represented a current and relatively stable dissociation in the child. As such, it gave evidence both of failure of integration and consequent lack of reality adaptation, and, concomitantly, a failure in object relating at a crucial point between mother and child (Balint, 1969). When confronted with the actuality of his symptomatic behaviour, the child disavowed it, either with a shrug of the shoulder, as with Paul's obsessional dustbin-searching, or with an outright denial that it had ever occurred, as with Stephanie's stealing, or with mute blankness, as with Jane's encopresis. For the surrogate parent the symptom comes to represent the child's 'other self', that part of the child which they, as substitute parents, did not create, and over which they have no control. The child, for his part, expresses through his symptom the alienation from the parental couple whom he knows to have 'chosen' him, but by the inherent arbitrariness of that choice, leave unresolved the confusion of his origins. Thus, a reported exchange between Paul and his father: F.: 'You eat as if you were in a pigsty'.

Paul: 'How do I know that I didn't come from a pigsty?'

I have described the child's attitude towards his symptoms as one of dissociation. The prototypical bodily expression of dissociation is evacuation of bowel and bladder. It is hardly to be wondered at, therefore, if the symptom formation of these children betrayed a markedly anal quality, and if the typical reaction on the part of the parents was predominantly one of disgust. It is my contention that the child's stool comes readily to symbolize the 'alienness', 'not of my flesh' of the child for the surrogate mother, and that, in consequence, particular difficulties are experienced over the toilet training of these children.

The process I am attempting to describe is primitive and paralogical. It originates in the realm of primary process activity, and as a reconstruction stands or falls, as Freud (1937) pointed out, by the degree to which it is capable of lending sense and sequence to a concatenation of disparate phenomena. It is for direct observation to support or refute the hypothesis proposed.

Let us begin with the two givens: on the one hand the parental couple (with the mother in the foreground), anxious to have the experience of possessing and rearing a child; on the other hand an infant of a few weeks, physically whole and viable, but requiring the complement of a single, stable maternal figure in order to develop and unify around an emergent self-identity the hitherto raw, irregular, and uncoordinated sensory impressions which have been evoked in the physical organism by stimulation from within and without. On the face of it, therefore, a mutuality of needs: the mother for caring, and the infant for care. If this were the whole truth, then the process might be expected to develop with the spontaneity and simplicity of a natural adaptive biological and social process, with the maturational process of the one meeting the facilitating environment of the other. However, at the moment of meeting, woman and baby are strangers to each other. The mother

has missed the gestation and parturition of this baby, and the baby has missed the experience of creation by and extrusion from this mother. Moreover, the basis of this synergism of mother and child, which is genetically determined and rooted in the physical constitution of both, is not merely absent: both partners to the prospective dyad have suffered some measure of active privation. In the mother this derives from the fact that the child is not her own, and from the anxieties and uncertainties attendant on adoption and fostering procedure, whilst for the child it derives from the destitution of a regular, preoccupied, caring figure, fully attuned to his needs.

A wealth of observational knowledge and therapeutic experience has acquainted us with the reactive processes evoked in the human organism by the absence of appropriate and timely need satisfaction. In the mother, as she has developed to maturity as an adult, these can assume a multiplicity of different forms: in the infant, as yet immature and labile, the repertoire of defensive reactions is relatively restricted and invariant (Spitz, 1965). In both partners, however, we may assume a continuing capacity for satisfaction. In other words, we postulate that the defensive reactions have not reached the stage of irreversible structuring, such that the mother (as a minimum) would not want to have a child, and the child would have evinced no capacity for object-relating. To summarize, therefore, what has been stated concerning the surrogate mother-to-be and the child: we predicate: (i) reciprocity of biosocial needs (or interest); (ii) absence of prior communality in earliest gestation, parturition and mother-and-babyhood; (iii) reactive processes evoked in both owing to the frustration of somatic and affective wants.

The meeting and linking of surrogate mother and child is a procedure of psychosocial engrafting. Physical medicine has acquainted us with the phenomena of rejection which regularly follow the transplant of an organ from one creature to another, whether

or not the two belong to the same species. I think we have reason for saying that an analogous process is set in motion when a child is united to a surrogate mother, at least in cases where this occurs when the infant's ego structure is as yet unformed. And just as, in the former case, the functional attributes of the transplanted organ to activate and sustain the life of the host organism may be rendered unavailing, unless the rejection phenomena can be neutralized, so with the accession of surrogate mother to the child the lack of prior symbiosis can be itself an instigator of affective estrangement and even ultimate sundering, unless the rejection phenomena implicit in the relationship can be counteracted.

In order to study what I have described as the potential 'rejection phenomena' inherent in the relationship of surrogate mother and child, it is necessary to hold in temporary abeyance all other factors deriving from the physical and psychological endowment of any individual mother and child, whether healthy or pathological, and attend only to the situation of any surrogate mother who adopts or fosters an infant at an early age and compare it with the situation of an ordinary mother with an infant of the same age. In so doing, I am not arguing against the importance that the former factors have in determining the eventual outcome for the child's object-relating; indeed, it should be obvious that I attach the greatest importance to these. It is simply that we should be cautious in assuming too readily that the greater prevalence of psychological disturbance in children with surrogate parents, as attested by several studies, is to be ascribed entirely to the greater psychological disturbance of prospective foster or adoptive mothers as a group, or to the preceding privation suffered by the infants they receive, or to the shortcomings of fostering or adoption procedure, important as such factors undoubtedly are, whilst we disregard those difficulties implicit in the very contract which militate against the establishment

of a congruent and satisfactory relationship.

For the natural mother who has had the experience of carrying her baby to term, the act of birth comes ideally as a naturally determined 'dispossession'. Gestation provides her with the basis for her later identification, parturition with the model of separation and individuation. Never will she be more 'at one with' the baby than when she carries him; never will she have to reject him more forcibly than when she gives him birth. These events provide the foundation for her adaptation to the infant's states, to his liveliness and to his quiescence. Given favourable circumstances, a healthy mother and a viable infant, 'good-enough mothering' can occur. The surrogate mother, for her part, has not been a partner in the earliest stages of the infant's maturation. She is sensitized to the 'not-me' of the baby. She has 'got' a baby, but has not 'had a baby'. For her the autonomy of the infant (in its physical aspect) has not developed out of the heteronomy of the embryo. Because of the 'prematurity' of her acquaintance with the 'aliveness' of the baby, aspects of the baby, his restiveness, crying or even his unresponsiveness, can assume the dimensions of a psychic insult for a mother anxiously endeavouring to establish an attachment tie which will enable her to be attuned and responsive to the infant's demands.

It is within the context of the inherent instability of the surrogate mother-child dyad that the infant's stool may be vested with significance as a symbol. The stool is the child's excretion, that which is expelled, removed, disposed of. As a production it is an act of the child; as a reproduction it is an act of the mother and baby. In that it issues through the child's autonomous bodily activity, the stool lends itself pre-eminently to become the symbolic representative of the conflict or incongruence between the psychical needs and physical state of mother and child. To adapt a term of Freud, we might say that surrogate mothers are prone to *suffer from reminiscences*

(Freud, 1910). The stool becomes, like the hysterical symptom, a 'mnemonic symbol' of the child's otherness, of that which she as a surrogate did not create.

The conflict can best be illustrated by explicating the two contradictory propositions, and their unconscious equations:

(a) *This is my baby* \neq *This was my baby* \neq *I bore this baby* \neq *I am bearing this baby.*

(b) *This is my baby's stool* \neq *This is what my baby bears* \neq *X (the baby who is 'not-me')* is bearing my baby \neq *I am not bearing my baby* \neq *This is not my baby.*

This dialectic makes intelligible the following obsessional touching ritual between Paul and his mother:

(Walking in the street) Paul: 'Do not touch anybody.'

Mother: 'Why?'

Paul: 'Because I shall have to touch them.'

Thus 'If you touch anybody, you will touch "not-me."'

'If you touch "not-me", you will touch my stool.'

'If you touch my stool, you will throw it away.'

'If you throw it away, you will throw me away.'

But 'I don't want you to throw me away.'

Therefore 'I shall make the "me" into "me-and-you".'

'I shall have to touch them.'

Returning to the formulations made familiar by Winnicott, we might say that the particular problem for surrogate mother and child is to establish an area of coincidence (or 'illusion') in the absence of the biological predispositions in the mother for the construction and maintenance of such an experience. Thus Paul's touching ritual may be understood as an attempt to restore the area of coincidence which is threatened by the mother's withdrawal. Similarly, Stephanie's thieving can be seen as an attempt to transform the 'not-me' of the surrogate mother (the money) into the 'me-and-you' of the area of coincidence. In this way, the full unconscious significance of the concern that

the mother should not know about her stealing becomes apparent, as being due to the unconscious fear that she must restore the 'not-you-and-me' to the mother. The conscious counterpart to this fear was the fear of being sent away from home, and the fear of being expelled from the school.

Among the pathological sequelae which can be observed in the ongoing relationships in these families, and which derive, I believe, from the aetiology I have proposed, one in particular deserves consideration.

Reference has already been made to the sometimes astonishing lack of rapport between parents and child. In two of the cases I have been considering, this was so striking as to call in question the capacities or suitability of the surrogate parents. A whole catalogue of inappropriate and ill-adjusted demarches by the parents could be gleaned from the case histories, suggesting the establishment of a fairly rigid sadomasochistic pattern of relating between parent and child. Thus Jane's mother chose the day of the baby's inoculation, at about 12 months, to make the first attempt at potting the child. I believe that the typical pattern found in such families is a direct consequence of the sundering, prematurely, of a barely established experience of 'illusion'.

If adjustment between mother and child is the product of a satisfactory experience of illusion, then with the failure to maintain it, or to evoke it with moderate constancy, there will be a falling apart of the partners, and the establishment of a relationship based on asynchronicity of meeting and response. That is to say, at the moment when one partner is moving towards the area of overlap, the other will withdraw; in the next phase, the same movement will occur, with the partners' roles reversed. Asynchronicity, and disenchantment, thus replace the communality and satisfaction of healthy mother-child interaction.

This cycle is well illustrated in the circumstances which led to the discontinuation of treatment with Paul. If mother showed

determination in bringing him to the clinic, Paul would rebel. If Paul was ready to come, mother would make difficulties. Eventually, it was arranged for mother and boy to come at separate times. At the time of Paul's appointment, however, mother was to be seen patrolling the entrance of the clinic, ostensibly to ensure that Paul kept his appointment. Paul had set out independently on his bicycle to come to the clinic, but, on seeing mother there, went by. Thus the clinic had come to represent unconsciously for both mother and child the area of shared experience. As a consequence, a defensive pattern of mutual thwarting was set in motion, which ultimately rendered the attempt to provide treatment unavailing.

Winnicott (1954*b*) has described the resultant defensive process where impingement has replaced adaptation as the development of the 'false self'. The 'false self' is based on compliance, and has as its protective function to guard the 'true self' from exposure and pain. Some features which Winnicott has ascribed to the formation of the false self were evident in each of these three patients. I would prefer to describe the emergent organization in the children under consideration as '*satellite ego structures*'. I believe that such a description directs attention both to the compliance which Winnicott evinces as a characteristic of such organizations, whilst underlining the dependent, labile and ultimately reactive processes which it subsumes. The satellite is dependent by necessity, not by choice. The child who has lacked the experience of good-enough mothering at the crucial period has to reconstitute the constantly fragmentary community of 'I-and-you'. The area of illusion, never experienced at the appropriate time as sure and stable, gives place to a repeated syndrome of establishment and fracturing by both partners. Ego autonomy is not achieved, and in its stead a satellite formation emerges in a constant state of tension between maintenance of communality and revolt.

Thus, in the therapeutic situation, the

process is recreated. I characterized the early stages of therapy with these children as one in which a passive attitude on the part of the child predominated. In this phase it was as though the ego functioning of the child had been made over to the therapist. I also described the sudden caesura imposed by a remark or action of the child: this is the satellite ego in revolt at its enthrallment. On other occasions, the therapist missed his way, the identity of the patient was lost, and he substituted another in its place: here the therapist's own ego is in revolt, resisting what is felt as an encroachment and a threat to his own identity. It was only by accepting and following through in the transference that the vagaries of these primitive object-relationships that the child's ego could gradually begin to abandon its satellite status with its twin fears of annihilation and engulfment, and take the first tentative steps towards reality testing and healthy ego development.

CONCLUSION

Clearly, the hypothesis here proposed to account for certain nosological factors in the surrogate mother-child relationship is in need of further elaboration and specification. In conclusion, I wish to dispel a possible source of misunderstanding to which my account could give rise.

I have alleged the absence of a prior biological tie between mother and child during the infant's earliest maturation before and around the time of birth as a contributory factor in cases of subsequent breakdown. I have suggested that this deficit for both mother and child can hinder the process of primary identification and affect the genesis of what Winnicott has termed 'primary maternal preoccupation' (Winnicott, 1956) in the mother.

An extreme application of this thesis would lead to the evidently absurd conclusion that all surrogate mother-child relationships, inasmuch as they suffer this deficit, are doomed to failure and, conversely, that all natural

mother-child relationships are ensured success. At this juncture, I am reminded of the cautionary aphorism of Hughlings Jackson: 'The tendency to appear exact by disregarding the complexity of factors is the oldest failing in medical history.'

What I am suggesting, therefore, is a more tentative proposition, namely that among the pathogenic factors the actual absence of this particular mother for this particular infant can have a detrimental effect on the earliest interactions between them when they come together, with cumulative consequences for the subsequent outcome of the relationship.

Since Kanner (1943) first described the syndrome, it has been widely accepted that the emotional 'unavailability' of the mother for the infant could have far-reaching implications in the development of autism and related psychotic conditions. The present paper suggests that the physical absence of the mother at this same crucial period may be the start of a pathology with some parallel manifestations.

Episodes in therapy similar to those reported in this paper may be familiar to those engaged in the treatment of severely regressed or schizophrenic patients. In this respect it is interesting to see a description of family interaction closely resembling that described between Paul and his parents in a recent study of the families of schizophrenics (Scott & Ashworth, 1967). Noteworthy, too, is the allusion to the role of the stool as a symbol of that which must be excluded yet reincorporated between child and mother in an early analytic approach to the problem of schizophrenia (Laforgue, 1927). Both the physical and emotional 'unavailability' of the mother to the child represent relatively severe disruptions of the infant's 'average expectable environment' (Hartmann, 1939). The similarities, if such they be, are suggestive of further avenues of exploration.

One difference between the two, however, is manifest and perhaps disquieting. Whilst we are generally impotent by social provision to deal preventively with the schizophreno-

genic mother, fostering and adoption are contracts which are socially sanctioned and actively encouraged. Given the palpable evidence from numerous studies of the high incidence of breakdown in these families, there seems an urgent need to study the causes of stress in order to evaluate how much this is endemic to the contract as such, so that means may be found of lessening the risk. The confrontation of biological and emotional ties is a commonplace of litigation in those cases where the natural mother seeks to reclaim the child that has been given over to the care of others. What is needful, it seems to me, is not to endorse one claim against the other, but rather to re-examine carefully the basis on which the dichotomy is made.

SUMMARY

Analytic material from the treatment of three children reared by surrogate parents is presented. Particular attention is paid to a characteristic interaction manifested by all three in the early sessions of therapy. The process is seen as comprising three phases: (i) a period of relatively sustained 'empathic convergence' of the therapist towards the unconscious, primary process of the patient; (ii) the reaction: a sudden 'divergence', initiated by an act, word or gesture of either patient or therapist, which appears, on its occurrence, totally discordant with what has gone before; (iii) the sequel: a realignment of both patient and therapist who now experience each other as separate or 'alien'.

The significance of this process is then explored in relation to the manner of relating, historic and current, of child and surrogate parents (in particular the mother). It is suggested that the prob-

lem facing the surrogate mother-child dyad is to promote the conditions for 'primary identification' without which adequate adaptation to the infants' needs, emotional and physical, cannot occur, in the absence of the physical preconditions for its occurrence.

The following hypothesis is then proposed to account for the pathogenesis: (i) that the unity of 'primary identification' in the surrogate mother-child relationship is inherently labile; (ii) that its breakdown is marked by the experience, for both mother and child, of premature 'disillusion'; (iii) that the child's stool becomes the pre-eminent symbol of the child's 'alienness'; (iv) that in consequence surrogate mothers are liable to experience more than usual difficulty over toilet training their children; (v) that this may account for the evidence of disgust, disappointment and rejection, which appear to characterize the mutual relationship of child and parent on referral; (vi) that the premature 'disillusionment' leads to the formation of a 'satellite ego structure' poised between compliance and rebellion, in place of healthy ego development in these children; (vii) that the action of this 'satellite ego structure' is revealed in the asynchronicity of meeting and response which is characteristic of the interaction between parents and child, and is reproduced in the ongoing therapeutic situation between child and therapist.

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Statistical prediction and 'cookbooks': a technological confidence trick

BY D. J. SMAIL*

The psychologist's traditional contempt for the arm-chair can at times have unfortunate results, mainly because by fleeing into experimental activity, by becoming dazzled by statistical sophistication and technological efficiency, he may forget to question the basis of his science and the ultimate purpose of his actions. In consequence he stands in danger of building around him an artificial world which, though possibly beautifully efficient within its own boundaries and elegant in its design, may bear no relation at all to anything that matters. At this point his only hope is to persuade others that his world is more real than theirs (Abramovitz & Abramovitz, 1970; Smail, 1970) or, on the other hand, to sit down, think and start again. A good example of the consequences of this kind of lack of reflexion may be seen in some of the results of the statistical v. clinical controversy, and it is the aim of this paper to focus on some of the arguments and assumptions involved in this relatively limited but important area of clinical psychology.

Today few clinical psychologists would question that nomothetic tests, processed by the appropriate statistical technique, provide more reliable predictions of significant clinical phenomena than do the judgements of clinicians. This standpoint was first systematically examined and elucidated in some eminently sensible observations of Meehl (1954), who pointed out that psychological tests which claim to measure psychological variables should be shown to do so, i.e. they should be shown to be valid. Via a number of subtle metamorphoses this argument has ended up by being presented as support for 'cookbook' methods of personality diagnosis (Fowler,

1966; Gilberstadt & Duker, 1965; Marks & Seeman, 1963) and computerized psychological reports (Fowler, 1969), none of which have been shown to be valid. Thus a rational scientific argument has led to an absurdity. What appears to have happened here is that a technological argument has become substituted for a scientific one; in other words, fascination with technique has replaced thought.

Several reviews have appeared summarizing the results of many studies which have been concerned with the relative accuracy of statistical (or 'actuarial') and clinical prediction (see, for example, Sawyer, 1966; Sines, 1970). The conclusion drawn is that statistical, i.e. probability, statements arrived at automatically are very much more accurate when it comes to making predictions about patients than are clinical judgements. Sine's (1970) concern is with how we may 'best, most accurately and most efficiently predict the socially, clinically and theoretically significant characteristics and behaviours of our patients'. In his review he restricts his attention 'to the 14 reports most concerned with topics of central interest to psychiatry and clinical psychology'. His conclusion is that of these 14 studies only one (Lindzey, 1965) favours clinical prediction.

On the basis of these and other studies, an enthusiastic advocacy of 'cookbook' methods of diagnosis and personality description has developed among some psychologists. Appeals are made to the practicability and economy of automatic systems where patients are assigned to a particular group on the basis of their having shown characteristics (usually test scores) actuarially frequent in that group. The relative fallibility of man versus machine is invoked: 'The prediction of human beha-

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viour and the description of personality are far too complex to be subject to half remembered norms and subjective extrapolation' (Fowler, 1969), and the attractions of computer-written psychological reports and considerations of cost-effectiveness lead to observations which belong more to marketing than to science, even though they be made tongue-in-cheek:

the development of cookbooks and the construction of actuarial programmes for the interpretation of psychological tests have involved an enormous amount of work aimed at formalizing and routinizing a number of procedures that have evolved over many years... To us they represent an inevitable step forward in the technology of assessment. Their development requires no new raw materials or radical departures from conventional procedures.

And again: 'The average consumer of the psychological report expects a practical product that requires little, if any, additional processing prior to use' (Marks & Sines, 1969). The future sounds rosy:

To the extent that practising clinicians are interested in the descriptive material provided by any of the existing actuarial systems, we may be able to realize one of the intended aims of actuarial methods – the economical and valid identification and prediction of socially and clinically important attributes of our patients (Sines, 1970).

The supreme test of a method is its degree of success or efficiency in predicting events in applied situations... By this criterion the actuarial approach has already demonstrated its superiority to personality theory (Shontz, 1965).

A superficial reading of these sources thus suggests that a clinical psychologist's paradise, if it has not exactly arrived, is in the process of being ushered in; the problems have been solved; valid, accurate predictions concerning significant events and 'behaviours' can be made, given a bit more money and computer time.

And yet the claims made and the visions seen appear on closer inspection to be surprisingly at variance with the facts.

For example, the word 'prediction' is used

extraordinarily loosely, and confuses prediction made within a given experimental situation about specific experimental data, with prediction in the sense of foreknowledge of a person's behaviour or of an event (similar confusions are frequently made by psychologists over concepts such as 'statistical significance'; see Bakan, 1966). To take Sines's (1970) review as an example, of his 14 studies less than half could be said to be predicting anything – the majority consisted of examining the relative efficiency with which statistical formulae or clinicians could assign patients to diagnostic or personality categories to which they already belonged, i.e. the patients had been diagnosed before the tests involved were administered. Similarly, the basis of the present cookbooks available, referred to above, is no more than post-dictive, i.e. patients showing certain characteristics have been sorted out according to their scores on certain tests, usually the MMPI, the predictions derived from these having yet to be validated.

Again, though prediction of *behaviour* is so frequently referred to, only one study refers directly to a behavioural criterion (overt homosexuality) and this is the single study that favours clinical prediction (Lindzey, 1965). Only two studies do predict *events* (length of stay in hospital). The rest refer to *judgements* of one kind or another: judgements, that is, concerning a patient's pathology, diagnosis or response to treatment. The vast majority of these studies therefore appear to point up a rather strange logic in the arguments advanced by the statistical prediction camp. In order to discredit the accuracy of clinician's judgements about patients, they attempt to show that statistical/actuarial methods can better 'predict' what these judgements have been, or (optimistically and by inference) would be. Sines recognizes this difficulty only partially where he states of the criterion, or original, judgements that: 'Error or unreliability in these criterion judgements puts a harsh upper limit on the maximum accuracy achievable by any prediction method' (Sines, 1970). It should be noted at this point that the

studies reviewed by Sawyer (1966) do tend to evaluate 'predictions of behaviour' in the true sense of the words; very few of them are, however, concerned with predictions or behaviour in the clinical field, but relate more to vocational or educational problems.

In truth, then, it seems that we are a long way from predicting events or behaviours of clinical interest. Mechanical methods, it appears, can merely assign patients to categories already assigned them by clinicians better than other clinicians can.

It is a feature of many clinical/statistical comparisons that some clinicians do as well as, sometimes slightly better than, the formulae (Holt & Luborsky, 1958; Kelly & Fiske, 1951; Sawyer, 1966), although the study of the varying predictive ability of individual clinicians has been, with a few exceptions (e.g. Holsopple & Phelan, 1954; Sarbin *et al.*, 1960), relatively neglected.

This fact – that one or two clinicians tend to be about as good as the statistical formula in most of the studies involved – is often dealt with in the statistical camp by special pleading which can lead into contradictions. In a study by Kleinmuntz (1963) eight expert clinicians did almost as well, and one of them just as well, as the formalized rules in assigning emotional maladjustment to students by means of the MMPI. In his consideration of this study Sines (1970) states:

We are probably quite safe in concluding that the average user of the MMPI would be somewhat less efficient than those eight experts, thereby giving the actuarial method an even greater edge over the clinical method.

Again, in discussing the one discrepant finding of Lindzey already mentioned, Sines argues that

because an actuarial formula developed on a sample of college students was applied to a sample of maximum security prisoners, Lindzey's study cannot be interpreted strictly as an instance of the superiority of the clinical method over the actuarial method of prediction. It does, however, clearly and unambiguously point to the importance of specifying the population used in the deri-

vation of any prediction formula, and it justifies a great deal of caution in the application of a prediction formula to persons from different populations.

However, five pages later the following argument is produced to offset the apparent limitations of cookbook methods:

There is also some encouraging evidence to suggest that some behaviour patterns found actuarially to be predictable from a particular test pattern within a psychiatric population may be validly associated with the same pattern of test scores, even when it is encountered in a non-psychiatric setting. . .

It is perhaps trivial to harp on logical inconsistencies of this kind, but on the other hand it may serve to emphasize the fact that preoccupation with technique and method can lead to blindspots in scientific thinking.

The position thus far may be summarized by pointing out that, whatever these studies do show, they do not provide convincing evidence of the ability of statistical methods (very rarely are they in fact truly actuarial) to predict *events* or *behaviour* of great significance to clinicians. Before passing on to further considerations one may finally assess the validity of these methods of 'statistical prediction' by quoting the views of some of their advocates: 'To our knowledge there have been no formal attempts either to cross-validate or to determine the validity generalization of the descriptors reported in cookbooks' (Marks & Sines, 1969).

In a formal sense, the computer-generated reports are neither more nor less 'validated' than reports prepared by the usual methods. The evidence for individual interpretative statements can be cited, but the global accuracy of psychological reports, however derived, has not yet been established (Fowler, 1969).

The limpness of Sines' (1970) attempt at mitigation of this problem of validity may be judged from the following:

Neither the Marks & Seeman nor the Gilberstadt & Duker work has been extensively cross-validated in the traditional meaning of that term.

There are, however, several MMPI profile patterns that appear in both Marks & Seeman and in Gilberstadt & Duker, and to this extent these two sets of personality descriptions offer some cross-validation of each other. One finds, on careful reading, that when a particular MMPI pattern is described in both works the descriptions are very similar.

As stated earlier, Meehl's original (1954) observations on the question of statistical *v.* clinical prediction were aimed at encouraging psychologists to establish the validity of the tests they used, and he was at pains to point out that properly validated tests on the whole work better than clinical intuition or undisciplined guessing. Most of the evidence supports this view: few psychologists would deny the need for validation and formalization of research hypotheses and psychometric instruments. However, paradoxically, the very evidence used to support this position has come to be used also as an apologia for mechanized judgements concerning people which have as yet not been demonstrated to be valid. The rest of this paper will be concerned with suggesting some of the possible reasons for this.

Part of the problem, no doubt, is the psychologist's present-day obsession with technology. The teaching machine in education and the shock-box in treatment are now finding their counterpart in the form of the computer-written report in clinical psychological assessment. Methodological means have become a technological end – science is abandoned. We have all the knowledge and the 'raw materials' – now we can stop thinking and set the whole process mechanically rolling.

This involves, of course, a wholesale acceptance of the existing classification systems. However accurately we can predict that an experienced psychiatrist will call a given patient schizophrenic, we shall be no further on in elucidating the meaning of this label or the consequences of it for the patient. Perhaps psychologists have become so bemused by being asked by their psychiatric colleagues to answer meaningless questions that they have

been brain-washed into accepting the system and look forward to the day when they can sit back and let a machine churn out their reports for them.

More likely, however, the continuing acceptance of a naive and simplified view of science is at the root of this new technological enthusiasm. The person has been left out of psychology at all levels – at the level of scientist as well as subject. The latter must be conceived of as operating mechanically if he is to succumb to the requisite 'prediction and control'; and the necessity for the former to obliterate his own biases and to remain objective means that he becomes ideally replaceable by a machine. Thus, by attempting to strip himself of influence, the psychologist becomes blind to the influence which he is in fact exercising (in mechanizing his subjects) and becomes in turn unable to control it. (This corresponds closely to Fromm's (1956) view of projection, in which qualities projected into others or on to things become out of control and leave the person diminished; psychological technology may thus be seen as part of a kind of psychologists' 'alienation syndrome'). Prompted by a feeling that concepts of consciousness and value are important to psychology, and no longer over-awed by the strictures of positivism and behaviourism, several psychological voices have been raised in recent years against the reductionist and objectivist views of scientific psychology and psychiatry (Abramovitz & Abramovitz, 1970; Bannister, 1970; Caine & Smail, 1969; Kelly, 1955; Rogers, 1961; Rychlak, 1970; Shotter, 1970; Smail, 1968; to mention only a few). Polanyi (1958) has argued in closely reasoned detail that traditionally unquestioned scientific precepts such as 'objectivity' are no more than insubstantial attempts to formalize procedures of rational thought which are in fact no more ultimately justifiable than is belief in magic, but which are in fact based on an intensely personal commitment to a particular world view. Psychologists need not only stop worrying about appearing to be scientific by aping the natural sciences, but they can

also take comfort from the reflexion that the natural sciences are equally unable to justify themselves by appeals to some ultimate, objective criterion.

It seems inconceivable that any psychologist can believe that the major difficulties in clinical and personality theory have been overcome to an extent sufficient for us to ossify any present nosological or judgemental system into an actuarial, computerized technique. Meehl himself (1954) pointed out that intuition and hypothesis-making need not be made explicit, but only the relation of the evidence to the hypothesis once it has been formulated. Experiment and validation form only a part of scientific endeavour; thinking, questioning, hunch and discovery are equally if not more important, and should not be abandoned in favour of the neutral and unreflective activity of the computer.

It is not, of course, the writer's intention to suggest that, as things stand, statistical prediction is *not* superior to clinical prediction. Care does however need to be taken over the significance we allow to the word 'prediction', and one must bear in mind that the evidence for the statistical position, however good so far, in no way justifies the use of the 'cookbook' approach, the validation of which is a quite separate issue.

Underlying this whole question, however, and at a higher level of abstraction, are issues to which psychologists could perhaps more profitably address themselves, and from a thorough consideration of which one might hope for advances of greater scientific magnitude than the computer-written psychological report. One such issue is that of prediction itself, i.e. whether prediction, clinical or statistical, is even a possibility where human behaviour is involved. This question is of course by no means new to psychology (see, for example, Burt, 1964; Scriven, 1964), but the arguments concerning it tend to be conducted somewhere on the periphery of the discipline, as a philosophical exercise which never quite reaches the laboratory or the practising clinician. Recently, however, Mair (1970) has given some indication of what the clinical psychologist who takes this kind of problem seriously might do.

In a challenging article Joynson (1970) has traced some of the factors involved in what he calls the breakdown of modern psychology. It is the writer's view that the 'cookbook' approach to personality assessment and diagnosis, underpinned as it is more by technological faith than by scientific discipline, provides a good example of one of the more florid symptoms of this breakdown.

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'Ego boundary' and the 'barrier score'

By RUSSELL MEARES*

A body of information is accumulating about the 'barrier score' devised by Fisher & Cleveland (1958). It is derived from responses to Rorschach cards. Those emphasizing boundaries are regarded as barrier responses. The following are examples: 'cave with rock walls, person covered with blanket, woman in fancy costume, mummy wrapped up, animal with striped skin, vase' (Fisher & Cleveland, 1965). It is assumed that these perceptions are projections of the individual's 'body image boundary'. That this notion is confusing might be explained in the following way.

The self might be conceived of as discrete, limited by an 'ego boundary', and having within it a number of unified constellations of emotions, ideas, images and remembered sensations. Such constellations have been given many names, amongst them 'symbol' and 'concept'. They are distinct, with boundaries of varying definiteness. They interconnect, nevertheless, and are in equilibrium with a constant and varying perceptual input. The two most important of these constellations concern the subject's experience of the first person who was other, or object, to him, and secondly the individual's experience of his body, which might be called the 'body image'. Using this hypothetical system, it is apparent that 'body image' is not the same as 'ego boundary'. Those who use the barrier score, however, seem to treat them as interchangeable terms.

A second and closely related confusion is highlighted by the following quotation from Fisher & Cleveland (1965). 'There is evidence that the individual has a unique way of perceiving his own body as contrasted to non-self

objects. As such, this body image or body concept...'. That is, concept and percept are also regarded as interchangeable.

It would seem reasonable to suggest that 'body image' represents a conceptual structure developed from experience, and that 'ego boundary' is a percept, or experience, at a particular point in time.

As barrier scores are said to be related to personality or life style, it might be assumed that Fisher & Cleveland believe they are reflexions of 'body image', and that barrier responses are projections of the definiteness or otherwise of the boundaries of this particular concept. It might equally be argued that they are reflexions of the rigidity of an individual's manner of concept formation in general. If it could be shown that individuals who form rigid concepts have high barrier scores, this argument gains some support. This paper attempts to show this.

METHOD AND RESULTS

Cleveland (1959) studied 17 patients with spasmodic torticollis. He found that they had very high barrier scores and concluded that they had 'a frozen and immobile kind of body image'.

Thirty-two people diagnosed as spasmodic torticollis at the Maudsley Hospital, London, were examined by the author. Many gave a clinical impression of showing obsessional character traits. They all completed the Sandler & Hazari (1960) questionnaire, which relates to obsessional traits and symptoms. As a group they scored higher than a normal group (Kline, 1967) in terms of obsessional personality, i.e. in terms of a scale which differentiated the neat, methodical, punctual, thorough, and meticulous individual. The

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difference between the mean of the normals, 6.4, and that of those with spasmodic torticollis, 10.4, was highly significant ($P < 0.001$). On the other hand, there was no significant difference between the two groups in terms of obsessional symptomatology (normal mean, 5.5; patient mean, 6.9).

DISCUSSION

The samples. Of all psychiatric diagnoses, spasmodic torticollis must be amongst the most reliable. It therefore seems valid to assume that Cleveland's group of patients were comparable with the Maudsley group. Rather similar mean ages of onset in the two groups also favour this assumption. The average age of onset of the Maudsley patients was 37.3 and of Cleveland's patients, 34 or 35.

The psychometrics. Fisher & Cleveland (1965) claim that 'the barrier index can be scored with high reliability, and adequate test-retest reliability has been shown'.

Sandler & Hazari's questionnaire has been severely criticized by Reed (1969). It will be argued elsewhere, however, that it is probably valid when scored by near-normals or by mildly ill psychiatric patients. Sandler & Hazari's sample was comprised of the latter.

Kline's 'normal' figures for this scale are inadequate, as the sample was mainly composed of students. The high significance of the result achieved in this case probably outweighs the imperfections of the normative data.

General. Assuming that these scores are manifestations of personality structure rather than spasmodic torticollis, it seems not un-

reasonable to conclude that obsessional personalities have high barrier scores. Cleveland concluded that the latter score implied a 'frozen and immobile kind of body image'. An obsessional personality might be expected to form compartmentalized, rigid, or 'frozen and immobile' concepts, amongst them a rigid 'body image' concept. There is no reason to suppose that the barrier score reflects more than a general style of organizing percepts at a conceptual level. This is consistent with suggestions (e.g. Wylie, 1961) that barrier score relates to 'cognitive style'.

SUMMARY

'Ego boundary' and 'body image' can be distinguished. Fisher & Cleveland's 'barrier score', which is said to measure the definiteness or otherwise of the 'body image boundary', is probably intended to measure the latter.

A particular diagnostic group showed obsessional personality traits and high barrier scores, indicating a 'frozen and immobile kind of body image'. Obsessional personalities characteristically form rigid or 'frozen and immobile' concepts. It is suggested that the barrier score reflects an individual's manner of concept formation in general, rather than a 'body image' concept in particular.

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Obsessionality, the Sandler-Hazari scale and spasmodic torticollis

By RUSSELL MEARES*

Sandler & Hazari (1960) published a questionnaire which purported to distinguish between obsessional personality traits and obsessional symptoms. Reed (1969) has made a number of damaging criticisms of this questionnaire. He showed that neither in terms of obsessional personality traits, nor in terms of symptoms, could it distinguish between groups of obsessional neurotics, depressives with obsessional personality traits, and a heterogeneous group of hysterics and psychopaths.

This report concerns a study which produced results which differed somewhat from Reed's.

METHOD

Some personality variables of 32 cases of spasmodic torticollis (Meares, 1971) were studied. The word 'obsessional' occurs in some descriptions of these patients. Sandler & Hazari's scale was used to investigate this impression. Of the other parameters investigated, the neuroticism (N) scale of the Eysenck Personality Inventory (EPI) (1964) was most relevant to this report.

Results were statistically analysed using the *t* test for uncorrelated data, unless otherwise stated.

RESULTS

Thirty-two cases of spasmodic torticollis showed a significant increase in obsessional personality traits when compared with a normal group (cf. Kline, 1967). (Mean score of normals, 6.4; of spasmodic torticollis, 10.4; $P < 0.001$.)

On the other hand, there was no significant difference, in terms of obsessional symptoms,

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between the two groups. (Mean score of normals, 5.5; of spasmodic torticollis, 6.9; P not significant.)

The spasmodic torticollis cases were significantly less neurotic than a group of 108 anxiety neuroses, used by Eysenck as a standard (1964). (Mean N score of neurotics, 15.8; of spasmodic torticollis, 11.4; $P < 0.001$.)

A group of 10 spasmodic torticollis cases scoring high on the neuroticism scale (i.e. 15 or above) were compared with the 22 remaining. The high neurotics showed significantly more obsessional neurotic traits than the low neuroticism scorers. (Mean of high neurotics, 10.9; of low neurotics, 5.2; $P < 0.001$.) On the other hand, high scorers for neuroticism showed significantly fewer obsessional personality traits. (Mean score of obsessional personality traits of high neuroticism scorers was 8.4, compared with 11.3 for low neuroticism scorers; $P < 0.05$.)

A linear regression of neuroticism against obsessional personality traits showed a tendency towards negative correlation ($r = -0.312$). This did not quite reach significance.

A linear regression of neuroticism against obsessional symptoms showed a positive correlation ($r = 0.617$; $P < 0.001$).

DISCUSSION

In this series of patients, there was an increase of 'obsessional personality traits' when compared with a normal population, but no increase of 'obsessional symptoms'. It might be said that the normal group of Kline (1967) is too small, too young, and far from random. Nevertheless, the difference was highly significant, and likely to outweigh the inadequacies of the control. It would seem, therefore, that in these 32 cases of spasmodic torticollis, 'obsessional personality traits' are

distinguishable from 'obsessional symptoms'. (These terms can only be used in quotes, for, as Reed rightly points out, there have been no studies on the Sandler-Hazari scale cross-validating clinical diagnosis.) Scale A, measuring 'obsessional traits', seemed to concern 'ego-syntonic' characteristics in that those patients with low neuroticism scores had significantly higher scores for 'obsessional traits' than high neuroticism scorers. The opposite was so when neuroticism was compared with 'obsessional symptoms', i.e. scale B. This scale correlated positively with neuroticism. On the other hand, there was a tendency towards a negative correlation between neuroticism and 'obsessional traits'. The fact that the two factors diverged when plotted against neuroticism is of interest, as it appears that in the study of Reed they moved together.

Different patient groups may partly explain the conflicting results. Sandler & Hazari used Tavistock out-patients, i.e. patients with only mild mental illness. The patient sample in this group were somewhat similar. On the other hand, Reed's patients were in-patients, and suffering from more severe disorder. Secondly, Reed explains that his group of obsessional neurotics also had obsessional personalities, so that no difference in scales A and B could be expected. He also suggested that some of his psychopathic group were 'wont to lay claim to every symptom suggested'. This left the depressives with obsessional personality traits as the critical group. They scored as highly as the neurotics on the 'symptom scale', although no obsessional symptoms were clinically discernible.

As the items on scales A and B seem to

comply with clinical descriptions of the obsessional personality and the obsessional neurotic it would seem unlikely that they measure anything else. It might be postulated then that they are *oversensitive*, i.e. that in a normal or near normal group they are likely to accurately select people with obsessional personalities or symptoms, but in a psychiatric population they lose any specificity. This is in accord with Reed's statement that the crude binary 'scoring' of the scales may be misleading, in that it provides information about the presence, but not the intensity, of experiences or attitudes.

Taking into account this report and that of Kline, it might be suggested that the Sandler-Hazari scale retains some validity when used on near normals, but has none when used on a population with more severe disorder.

SUMMARY

The Sandler-Hazari scale (1960), when used to detect 'obsessional personality traits' and 'obsessional symptoms' on 32 cases of spasmodic torticollis, showed evidence of the former but not the latter. There was a significant correlation between neuroticism (as measured by the N scale of the EPI) and 'obsessional symptoms', and a non-significant inverse correlation between neuroticism and 'obsessional personality traits'. Patients with low scores for neuroticism had significantly higher scores for 'obsessional traits' than high scorers, i.e. 'obsessional traits' seemed to be ego-syntonic. The discrepancy between these results and those of Reed (1969) is discussed.

The data in this paper form a small portion of a thesis awarded a Doctorate of Medicine at Melbourne University.

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EMANUEL MILLER

(Facing p. 183)

Obituary

EMANUEL MILLER

Dr Miller's brilliant undergraduate career, which embraced mental and moral science, provided the pattern of his subsequent contribution to British psychiatry. At Cambridge he was influenced by teachers of the calibre of Bartlett, McTaggart, Russell, Moore, Rivers, Johnson, and Dawes Hicks, and he developed an interest in experimental psychology which lasted for the rest of his life. Three threads ran through his subsequent approach to medicine and psychiatry: scientific psychology, anthropology, and philosophy. He took his medical training at the London Hospital and, influenced by Henry Head, was soon immersed in the study of the central nervous system and in particular of the many ex-Service patients suffering from wounds of the spinal cord and cerebellum to be found in the Royal Army Military Hospital at Millbank. During this period Trotter, Sargant, and Buzzard contributed to his thinking and he was eventually appointed neurologist to the Ministry of Pensions. His concern with psychiatry was manifest at this time by his contribution to the course at Cambridge for the Diploma in Psychological Medicine.

Dr Miller turned increasingly to psychiatry and in the early twenties was appointed to the staff of the West End Hospital for Nervous Diseases. A special interest in criminology and forensic psychiatry led to his sitting with Mr Basil Henriques in the East London Juvenile Court and in turn to the foundation of the East London Child Guidance Clinic linked with the London Jewish Hospital - the first Child Guidance Clinic in this country. He shared with Professor Mannheim and Dr Glover in the founding of the Institute for the Scientific Treatment of Delinquency and became Joint Editor of the *British Journal of Criminology*.

During the war he became lieutenant-colonel in the Royal Army Medical Corps, and worked at the Military Hospital, Northfields, where he took part in the training of many young army psychiatrists. He also was actively involved with the work of the War Office Selection Boards and in the mental health of young recruits.

After the war Dr Miller joined the Maudsley Hospital as consultant psychotherapist and became honorary physician in child psychiatry to St George's Hospital. At the Maudsley he contributed richly to the training of many young psychiatrists of the immediate post-war period, and although representative of the eclectic psychotherapy which has played so big a part in the history of British psychiatry, he maintained an early interest in typology shown in his book *Types of Mind and Body* and by his introduction of Kretschmer's work to British readers. He also taught in the early years of the mental health course and later instructed medical undergraduates at St George's Hospital. His strength as a teacher stemmed not only from the width of his technical knowledge but also from his enjoyment of the role and his capacity for expressing himself eloquently and with polish. As a writer Dr Miller again exercised this fortunate combination of rich content and good style. His early book *The Generations* was the forerunner of much that was later to be written on family dynamics and therapy and during his period at the Tavistock Clinic his interviews with parents in the Children's Department stemmed from the same interest. He published papers steadily throughout his career and in 1968 edited *Foundations of Child Psychiatry*, a book composed of contributions from an international panel of authors to which he

contributed a valuable chapter on the problem of classification in this field.

To those learned societies in whose cause he believed he gave his time generously. In addition to his contribution to criminology he was a member of that group of British psychotherapists who worked hard to establish the Medical Section of the British Psychological Society and he was elected chairman of the Section in 1934, taking for his chairman's address the theme 'The Present Discontent in Psychopathology'. He was a founder member of the Association of Child Psychiatry and Psychology, its first chairman and co-editor of its *Journal*. His

contribution to the first number, published in 1960 and entitled 'A Discourse on Method in Child Psychiatry', was in many ways the epitome of his approach.

It would be impossible to evaluate Dr Miller's contribution without mentioning that for the last two decades of his life, during which he continued to work and to publish, he was handicapped by severe, increasingly crippling rheumatoid arthritis. A man without interest in power or medical politics, he was essentially a scholar, a painter of no mean ability and a student of art and of letters.

G. STEWART PRINCE

Short Book Notices

The Child's Conception of Time. By JEAN PIAGET. (Translated from the French by A. J. Pomerans.) London: Routledge & Kegan Paul. 1969. Pp. xi + 285. £2.25.

This is a valuable English translation of a work written in 1927. The first part of the book is devoted to a discussion of a laboratory experiment and to the methods young children use in ordering successive events and in estimating durations. The second part deals with various operations in physical time, while the third part analyses 'lived' time – the notion of age and psychological duration – in the light of the first two sections. Professor Piaget and his collaborators apply the idea of groupings to the development of the child's concepts of motion, velocity and time.

Object Love and Reality. By ARNOLD H. MODELL. London: Hogarth Press and Institute of Psycho-Analysis. 1969. Pp. x + 181. £1.50.

As psychoanalysis does not yet possess a satisfactory theory of object relations, Dr Modell has tried to show that there is a latent theory which is capable of being extracted from within Freud's work. He attempts to reconcile Freud's theory of narcissism with recent clinical knowledge of borderline and schizophrenic patients, and outlines a unified theory of object relationship. He then goes on to propose a scheme for conceptualizing progressive and regressive changes in object love, using both topographic and structural metaphors.

Stimulation in Early Infancy. Edited by ANTHONY AMBROSE. New York and London: Academic Press. 1970. Pp. xvi + 289. \$12.00, £4.00.

In an attempt to define and synthesize the many hypotheses relating to the impact of the environment on the developing human being, a study group examined recent findings, theory and methodology in studies of the effects of early stimulation

normally provided by the mother. These studies, of both animal and human subjects, stress the biological and social aspects of the relationship between very early stimulation and later development. The papers and discussions reflect the multidisciplinary approach, and are intended to be of interest to researchers, teachers and students in child psychology and psychiatry, paediatrics, ethology, endocrinology, genetics and social anthropology.

The Broad Scope of Psychoanalysis: Selected Papers of Leopold Bellak. Edited by DONALD P. SPENCE. New York: Grune & Stratton. 1967. Pp. vi + 392. \$14.75.

The Broad Scope of Psychoanalysis is regarded as all of human behaviour. This volume deals with psychoanalysis not only as a theory of psychopathology and a form of treatment, but also as a general psychology of personality. This personality theory is stated in terms of the generally accepted propositions of science, and as experimentally explored. It is regarded as capable of comprehending human experience ranging from the schizophrenic to the emotions involved in reading a detective story. For the clinical psychiatrist, Dr Bellak's papers on psychodynamic drug evaluation may be especially interesting. Other topics extend from systematic presentations of cornerstones of psychoanalytic theory and technique to research into psychoanalytic concepts and processes. Virtually all the papers attempt to bridge the gap between experimental psychology and clinical psychoanalysis and psychiatry.

Attachment and Loss. Volume 1: Attachment. By JOHN BOWLBY. London: Hogarth Press and Institute of Psycho-Analysis. 1969. Pp. xx + 428. £3.15.

The author describes a theory of instinctive behaviour, derived from ethology and control systems theory, that he believes can provide psychoanalysis with a foundation in biological theory. Attachment behaviour is presented as a distinct form of instinctive behaviour and one that, though

most evident during childhood, nonetheless persists throughout life. Its function is postulated as protection from predators, a function as important for survival as nutrition and reproduction but hitherto neglected. A detailed account is given of the way attachment behaviour develops during the early years.

Motherhood and Personality. By LÉON CHEROK. London: Tavistock Publications. 1969. Pp. xvi + 303. £2.75.

The essential aim of this book is to identify the factors which predispose towards a 'good' or a 'poor' confinement, and to assess the beneficial influence of methods of preparation for childbirth. The author considers that it should be possible to predict the quality of a confinement, and to take whatever action might seem necessary to achieve a successful outcome.

Pain and Emotion. By ROGER TRIGG. London: Oxford University Press. 1970. Pp. viii + 187. £2.10.

Dr Trigg examines such questions as whether pain is a sensation or an emotion, whether it has to be unpleasant, whether it is the opposite of pleasure, etc. These problems are studied from the standpoint of a philosopher, and the author draws on recent medical research and quotes from the case-histories of patients. He attempts to establish that physical pain is a definite kind of sensation which is logically distinct from our normal dislike of it.

Expanding Concepts in Mental Retardation: a Symposium. Edited by GEORGE A. JERVIS. Springfield, Ill.: Thomas. 1968. Pp. xiii + 262. \$12.50.

The 44 contributors to this volume write on subjects in which they have considerable experience, and discuss the role of genetics, and nutritional and intellectual deprivation in the causation of mental retardation. They indicate the importance of basic principles of neurogenesis for a better understanding of the problem of mental retardation, and finally attempt an evaluation of modern techniques in the treatment and care of the retarded.

Aversion Therapy and Behaviour Disorders: an Analysis. By S. RACHMAN AND J. TEASDALE. London: Routledge & Kegan Paul. 1969. Pp. xiii + 186. £2.00.

This book seeks to formulate a constructive analysis and evaluation of the theory and practice of aversion therapy. The authors attempt to evaluate its clinical effectiveness and analyse the theoretical nature of the therapy in relation to aspects of the psychology of learning.

The Treatment of Mental Illness. By T. M. CAINE AND D. J. SMAIL. London: University of London Press. 1969. Pp. 192. £1.75.

The authors describe their own and other people's attempts to measure the values and beliefs of those involved in the treatment of the mentally ill, as well as some of the results that such beliefs give rise to. They discuss the leading schools of organic and psychotherapeutic treatment from the point of view of theory and research, and give special attention to 'therapeutic community' methods. Their conclusions call into question many accepted assumptions in psychiatry and psychology, and bring into focus a view of the therapeutic relationship which has been neglected by those responsible for the psychiatric patient.

On Sigmund Freud's Dreams. By ALEXANDER GRINSTEIN. Detroit, Michigan: Wayne State University Press. 1968. Pp. 475. \$17.50.

In this book the author reviews nineteen dreams Freud had between 1895 and 1900, the period when Freud began his personal analysis. The purpose of this book is to study Freud's associations by examining in detail the many allusions in the dreams. The book does not aim to reanalyse Freud's dreams, but to add additional material about the sources of the dreams, not easily available.

Abnormal Hypnotic Phenomena, vols. 3-4. Edited by ERIC J. DINGWALL. London: Churchill. 1968. Pp. viii + 216 and viii + 174. £2.50 per volume.

The aim of the volumes in this series is to bring to light the almost unknown and forgotten activities of the mesmerists of the nineteenth century, while concentrating on the paranormal aspects of their work. Volume 3 deals with Russia and Poland,

Italy, Spain, Portugal, and Latin America, 1800-1900. Volume 4 is concerned with the United States of America and Great Britain.

Depth Psychology and a New Ethic. By ERIC NEUMANN. London: Hodder & Stoughton. 1969. Pp. 158. £1.75.

The author addresses himself to the entirely new situation which has arisen, from the point of view of ethical problems, since modern psychology has broadened its scope by the study of unconscious processes. There is a foreword by C. G. Jung.

Transference and Countertransference. By HEINRICH RACKER. London: Hogarth and Institute of Psycho-Analysis. 1968. Pp. xi + 203. £2.10.

Dr Racker's papers, brought together in this volume, relate to a line of thought in psychoanalysis devoted to elucidating the ways in which the psychoanalyst's own responses to his patient influence the joint venture of psychoanalytic treatment.

Student Casualties. By ANTHONY RYLE. London: Allen Lane The Penguin Press. 1969. Pp. 152. £1.50.

This is a review of breakdown and failure among students which lays emphasis on both the personality and psychiatric problems of the individual student and on the importance of the relationship between the stress and support of the university. The first half of the book examines the special problems of the student age-group and the evidence about casualty rates, while the second part considers special problem issues such as suicide, pregnancy, and drug-taking. It concludes with a discussion on the function of the university health services.

Sex and Gender. By ROBERT J. STOLLER. London: Hogarth Press and Institute of Psycho-Analysis. Pp. xvi + 383. £2.50.

In order to find clues to gender development in more normal people, Dr Stoller describes patients with marked aberrations in their masculinity and femininity - primarily transsexuals, transvestites and patients with marked biological abnormalities of their sex. The author shows that sex and gender are not necessarily related in humans, and that the

sense of gender is almost always the result of psychological, not biological factors. Detailed data are presented on people with marked cross-gender aberrations.

Dialogue with Sammy. By JOYCE MCDUGALL AND SERGE LEBOVICI. London: Hogarth Press and Institute of Psycho-Analysis. 1969. Pp. x + 273. £2.75.

This is an account of the analysis of a ten-year-old boy who demanded that his analyst write down his fantasies and stories verbatim. Thus, in a sense, the patient is the author, providing the core material which stimulated Mrs McDougall and Dr Lebovici to add a full account of the psychoanalytic sessions, with appropriate commentary. The book shows insight into the inner world of a psychotic child.

Developments in Psychoanalysis at Columbia University. Edited by GEORGE S. GOLDMAN AND DANIEL SHAPIRO. New York: Hafner. 1966. Pp. xv + 357. \$12.50.

This volume offers a representative cross-section of clinical, theoretical and research applications of the adaptational approach to psychoanalysis as currently conceived at the Columbia Psychoanalytic Clinic.

Anorexia Nervosa. By PETER DALLY. London: Heinemann. 1969. Pp. 137. £1.50.

This book is based on a study, conducted over many years, of 140 female cases of anorexia nervosa. Six men with a similar condition, and a number of anorexia nervosa-like conditions, are described and distinguished.

The Mental Health Counselor in the Community. By DAVID S. SHAPIRO, LEONARD T. MAHOLICK, EARL D. C. BREWER AND RICHARD N. ROBERTSON. Springfield, Ill.: Thomas. 1968. Pp. xii + 207. \$12.75.

This book reports on a three-year mental health programme centring on the training of physicians and ministers in standardized methods for the management of emotional and social problems of patients and parishioners seeking help.

Brother Animal. By PAUL ROAZEN. London: Allen Lane The Penguin Press. 1970. Pp. xx + 221 + v. £2.25.

The author attempts to trace the events of Victor Tausk's life, and in particular his relationships with Freud. Tausk is a figure in the history of psychoanalysis about whom little is known, and Paul Roazen has tried to fill in the gaps. He has succeeded in producing a most readable story.

Schizophrenia and the Need-Fear Dilemma. By DONALD L. BURNHAM, ARTHUR I. GLADSTONE AND ROBERT W. GIBSON. New York: International Universities Press. 1969. Pp. xv + 474. \$12.00.

This book is the product of work begun at the Chestnut Lodge Research Institute where, for six years, a study was made of the significance of interpersonal relationships in schizophrenia. Detailed information concerning the relationships of a group of chronically schizophrenic men with hospital staff members was collected from their psychotherapists and from a variety of other staff members. Methods employed included interviews, questionnaires and direct observations. The collation of this information revealed patterns which were not apparent from separate study of either the doctor-patient or the ward staff-patient relationships.

One of the salient patterns emerging was called the 'need-fear dilemma'. This became central to an object relations theory of schizophrenia, presented in this book. The theory postulates that disordered object relations in infancy and childhood may interfere to such a degree with normal developmental processes of differentiation and integration that the person is seriously predisposed to schizophrenic disorganization. The major personality deficiencies which result are discussed, and it is claimed that much of the schizophrenic patient's social behaviour may be understood in terms of the reactions arising from the basic deficiencies.

Several chapters are devoted to special problems in the schizophrenic patient's relationships with hospital staff members and in his adaptation to the hospital as a social system.

Men in Mid-Career: A Study of British Managers and Technical Specialists. By CYRIL SOFER. London: Cambridge University Press. 1970. Pp. xxii + 376. £3.50; paperback, £1.10.

This book deals with the problems of men aged 35-40 who have invested half a working life in one type of career and may now be at a turning-point. The author reviews the literature on the subject and goes on to report on a detailed study of representative samples of managers and technical specialists. The book juxtaposes the viewpoints of senior management and the man whose career is simultaneously a building block in a task-centred system and the repository of his identity.

The Language of Emotion. By JOEL R. DAVITZ. New York: Academic Press. 1969. Pp. x + 197. \$10.00.

This volume reports recent research developments on the language used to describe emotional experiences. On the basis of empirical investigation, a dictionary of emotional meanings is developed, reflecting common elements in reports of experiences associated with a variety of emotional terms. On the basis of these definitions, an underlying structure of emotional meaning is identified, and this structure is considered in relation to a number of theoretical interpretations of emotional phenomena. Following this descriptive material, a final section deals with related studies, such as the development of the language of emotion and a cross-cultural comparison of emotional reports.

Fraser House: Theory, Practice and Evaluation of a Therapeutic Community. By ALFRED W. CLARK AND NEVILLE T. YEOMANS. New York: Springer. 1969. Pp. xv + 282. \$7.50.

The authors describe a therapeutic community in action, and aim at quantifying and measuring phenomena located and understood through conceptual analysis. The data are analysed from both a psychological and a sociological viewpoint. A number of insights deriving from this examination of the therapeutic community are described.

A Textbook of Psychosexual Disorders. By CLIFFORD ALLEN. Second edition. London: Oxford University Press. 1969. Pp. viii + 478. £3.50.

This work is divided into eight parts. The first discusses the sexual instinct and its development. The second considers disorders of sexual expression, the third disorders of the instinctual object, the fourth disorders of the sexual stimulus, and the fifth disorders of the instinctual strength. Part six is devoted to prostitution, and part seven to the prevention, treatment and prognosis of the psychosexual disorders. The remaining part deals with the medico-legal aspects of psychosexual disorders.

In this new edition the text has been revised and brought up to date. New references have been included.

Transsexualism and Sex Reassignment. Edited by RICHARD GREEN AND JOHN MONEY. Maryland and London: Johns Hopkins Press. 1969. Pp. xxii + 512. £7.15.

The text of this book brings together over 30 contributors from the United States and Europe, representing psychiatry, psychology, endocrinology, neurology, gynaecology, surgery, and the law. The book discusses the problem of the transsexual (who is distinguished from the homosexual and transvestite). The transsexual can be regarded as a female within a male body, or a male within a female body. Recently a number of attempts have been made to determine what constitutes transsexualism and to treat those suffering from it surgically. The papers provide an extremely extensive review of the whole field, and a follow-up study of 35 post-operative transsexuals is included. A glossary of technical terms is also provided.

The Psychopathology of Adolescence. Edited by JOSEPH ZUBIN AND ALFRED M. FREEDMAN. New York: Grune & Stratton. 1970. Pp. x + 342. \$15.75.

This book contains a series of papers by a variety of authors on ecological factors in adolescence; developmental and learning aspects of adolescence; psychophysiological, genetic, and internal environmental aspects of adolescence; and psychopathology of adolescence. The papers cover a wide variety of topics, ranging from 'the revolt of

youth' to eating disorders in adolescence and depression in the adolescent character disorder.

Sex and the Unborn Child. By ROMAN RECHNITZ LIMNER. New York: Julian Press. 1969. Pp. xxiii + 229. \$6.95. (Review copy issued by Biomedical Book Service, \$5.50.)

The author argues that intercourse during pregnancy may be damaging to the unborn baby.

Interaction Concepts of Personality. By ROBERT C. CARSON. London: Allen & Unwin. 1970. Pp. xiv + 306. £3.00.

Starting from a Sullivanian basis, in which personality is seen as a largely interpersonal phenomenon, the author attempts to reformulate Sullivanian conceptions into a more complete framework, more firmly tied to observable events or empirically testable hypotheses. This work represents an effort to integrate, from available empirical findings and conceptual formulations within psychology and the social sciences, a comprehensive account of socially significant personal conduct.

An International Symposium: Psychiatric Epidemiology. Edited by E. H. HARE AND J. K. WING. London: Oxford University Press, for the Nuffield Hospital Trust. 1970. Pp. xvi + 379. £4.00.

A vast amount of epidemiological research in psychiatry is now being carried out, and the present volume contains reports by some of the foremost workers in this field. Recent studies are described, and the directions in which the most rapid progress is being made are indicated. The contributors, sociologists as well as psychiatrists, come from North America and from many countries of Europe.

Essential Principles of Psychiatry. By S. CROWN. London: Pitman. 1970. Pp. x + 297. £3.00.

After an introductory chapter discussing the fundamental issues in psychiatry, the author pinpoints the many aspects of psychiatry under five basic principles: the genetic, the descriptive, the psychological, the psychoanalytic, and the social.

Part 2 is concerned with the normal personality, and contains a chapter dealing with reaction to stress, particularly developmental stress in relation to adolescence, marriage, old age, and the problems of the dying patient. Part 3 is devoted to personality disorders, psychoneuroses, and psychosomatic medicine, with an emphasis on conditions seen in medical practice, in the community, and in the psychiatric departments of general hospitals. Part 4 covers the major affective disorders, including a chapter on organic psychiatry, in which psychological reactions of the individual to organic disease are emphasized. Attention is drawn to the psychiatric complications of complex medical and surgical treatments such as 'spare part' surgery. Part 5 considers methods of treatment, stressing the concept of the therapeutic community and the psychiatric team.

While this book is aimed particularly at medical students and psychiatrists in training, it should certainly have a wide appeal to workers in clinical psychology and psychiatric social work, as well as in other specialist groups.

Your Mind and Your Health. By H. GUNTROP. London: Allen & Unwin. 1970. Pp. 149. £0.60.

This book amplifies a series of broadcast talks in 'The Silver Lining' feature of the B.B.C. Light Programme in 1950. The aim of the book is to banish the shame and allay the fear that many people have about the fact that they suffer from 'nerves'. Dr Guntrop attempts to explain emotional conflicts in simple terms, and the book is aimed at both the student and the general public.

The Capacity for Emotional Growth. By ELIZABETH R. ZETZEL. London: Hogarth Press. 1970. Pp. 316. £3.15.

In this volume Dr Zetzel has set out her approach to the 'prerequisites for emotional growth'. Her interest in the positive value of the capacity to tolerate manifest anxiety was first aroused through her experiences with soldiers during World War II. Her subsequent psychiatric and psychoanalytic experience has led her to develop a related approach to the implications of depression as a basic affective state. Dr Zetzel emphasizes the importance of early object relations for future emotional maturity, and this influences her clinical approach to psychiatric diagnosis and the indications for different psychotherapeutic techniques.

The first part of the book deals with subject-matter relevant to the relation between psychiatry and contemporary psychoanalytic knowledge. The second is mainly concerned with clinical psychoanalysis.

Freud: Political and Social Thought. By PAUL ROAZEN. London: Hogarth Press. 1969. Pp. xii + 322. £2.50.

The author believes that studying Freud's social thought can help us arrive at deeper understanding of Freud's mind and character, and hence of his psychology and limitations. A distorted view of psychoanalytic theory is thought to have resulted from past tendencies to focus exclusively on Freud's social thought, apart from his clinical contributions. The author attempts to reunite the social and clinical strands in Freud's work.

Teaching Psychosocial Aspects of Patient Care. Edited by BERNARD SCHOENBERG, HELEN F. PETTIT AND ARTHUR C. CARR. New York and London: Columbia University Press. 1968. Pp. xii + 420. £3.80.

This book is the outcome of a symposium held at Columbia University. A multidisciplinary approach for teaching psychological and social aspects of patient care is described and discussed by representatives of nursing, medicine, psychiatry, psychology, sociology, social work, and theology.

Personality: a Behavioral Analysis. By ROBERT W. LUNDIN. London: Collier-Macmillan. 1969. Pp. 464. £3.75.

This revised edition of an earlier work of the author attempts to integrate the study of personality within the framework of general experimental psychology and learning theory.

Studies in Word-Association. By C. G. JUNG. (Translated by M. D. EDER.) London: Routledge & Kegan Paul. 1969. Pp. ix + 575. £3.50.

This important collection of articles by Jung, Binswanger, Bleuler and other pioneers of analyti-

cal psychology was first published in 1918 by Heinemann and has long been out of print. The essays describe experiments in the diagnosis of psychopathological conditions carried out under the direction of C. G. Jung at the Psychiatric Clinic of the University of Zürich. The topics considered include the associations of normal subjects and of epileptics; the association experiment in relation to reaction-time, psychoanalysis, dreams and hysterical symptoms; and disturbances of reproduction in the experiments. The material by Jung will eventually be published in volume II of his *Collected Works*.

Industrial Organizations and Health. Volume 1: *Selected Readings*. Edited by FRANK BAKER, PETER J. M. MCEWAN AND ALAN SHELDON. London: Tavistock Publications. 1969. Pp. xvi + 699. £4.50.

The authors regard it of vital importance to understand the interaction between the individual and his working environment, and, in particular, to explore the ways in which the structure of the organization both affects and is affected by the mental and physical health of the employee. The present selection of papers makes available a wide range of material for those professionally concerned, in the practical or the academic context, with problems of environmental health and personnel management.

The Desegregation of the Mentally Ill. By J. HOENIG AND MARIAN W. HAMILTON. London: Routledge & Kegan Paul. 1969. Pp. x + 266. £2.25.

The present book investigates one of the most radical of the new ventures in psychiatric care, namely a comprehensive service of in-patient and out-patient care extended to the mentally ill by a psychiatric unit which is an integral part of a general hospital and the centre of a well-defined and accessible catchment area. The authors attempt to show the preference of the public for services of this type, and emphasize the need for close medical and social collaboration if such a service is to be maintained.

Psycholinguistics. By FRIEDA GOLDMAN EISLER. London: Academic Press. 1968. Pp. viii + 169. £2.50.

This volume presents and discusses experiments aimed at increasing an understanding of the generative processes involved in the production of speech. Special emphasis is placed upon the measurement of extralinguistic phenomena in spontaneous speech, but structural aspects have also been studied. These findings are relevant to all those workers who are interested in evidence about changes in the states of speakers in relation to the properties of the speech and language generated.

Marriage and Personal Development. By RUBIN BLANCK AND GERTRUDE BLANCK. London: Columbia University Press. 1969. Pp. xiv + 191. £2.70.

This study of marital counselling follows the theme of psychoanalytic ego psychology which proposes that the significant development of the personality in early childhood occurs in definable phases. These phases can be understood as reference points for the diagnosis of developmental problems in later life. The authors attempt to show how the marriage counsellor may recognize the developmental features in marriage and address his treatment to them.

The Genesis of the Classical Conditioned Response. (International Series of Monographs in Experimental Psychology, volume 8.) By IRENE MARTIN AND A. B. LEVEY. New York and London: Pergamon Press. 1969. Pp. xiv + 145. \$9.00, £3.35.

The authors describe recent developments in the field of classical conditioning, drawing chiefly on eyelid and autonomic conditioning studies carried out by themselves and by other workers. They suggest that detailed observation and analysis of the elementary characteristics of conditioned responses can lead to new understanding of the nature of conditioning. On the basis of their observations, the authors attempt to show that the simple classical conditioned response is a complex, closely integrated adaptive response, which increases in efficiency as it develops. A theoretical model is presented which elucidates aspects of conditioning not accounted for by older theories.

Pragmatics of Human Communication. By PAUL WATZLAWICK, JANET HELMICK BEAVER AND DON D. JACKSON. London: Faber & Faber. 1968. Pp. 296. £2.50.

This is a study of the theory and practice of communication. The first two chapters deal with the principles of communication; the rest of the book is concerned with the application of these principles with special reference to psychopathology, in cases where the communication system has gone wrong. In this connexion the authors refer in detail to the breakdown of communications in schizophrenia.

Social Learning and Personality Development. By A. BANDURA AND R. H. WALTERS. London: Holt, Rinehart & Winston. 1969. Pp. ix + 329. £2.00.

This book outlines a set of social-learning principles that emphasize the role of social variables to a greater extent than previous existing theories, and, the authors believe, appear more capable of accounting for the development and modification of human behaviour. The socio-behaviouristic approach in this book represents an integration of the authors' own research efforts and an attempt to relate these to findings obtained from controlled investigations in a number of areas. The authors believe that the whole range of social behaviour can be accounted for by a single set of social-learning principles. The original edition of this book was published in 1963.

Difficulties in the Path of Psychoanalysis. By ANNA FREUD. New York: International Universities Press. 1969. Pp. 83. \$4.00.

This small volume contains the Freud Anniversary Lecture given in New York in 1968. Miss Freud dissects the difficulties which arise from the side of the attitude of the public, the patients, and the analysts themselves. There is a useful bibliography of publications by Miss Freud.

Society without the Father. By ALEXANDER MITSCHERLICH. London: Tavistock Publications. 1969. Pp. xi + 329. £3.00.

The author seeks to trace the tension between the individual and society. He sees the origin of this in the breakdown of traditional norms and values that has accompanied the rise of industrial mass society. In emancipating himself from the restrict-

ive behaviour patterns of traditional life, man has also discarded the security of the old world order. The authority structure based on the image of the father—in the family, the church, and the state—is in dissolution, but no new model has arisen to take its place. Instead, the sources of power are perceived as increasingly diffused and anonymous, as in bureaucratic organizations, and the individual lacks a focus for identification and orientation. He responds to this uncertainty by anxious, regressive and often destructive behaviour. Professor Mitscherlich suggests that the key to the solution lies in the processes of evolution out of which human consciousness has developed. The next step for man is to learn to apply his reason to the control of his own inner impulses.

Schizoid Phenomena, Object-Relations and the Self. By HARRY GUNTROP. London: Hogarth Press. 1968. Pp. 437. £3.60.

This book is a sequel to Dr Guntrop's theoretical study of the emergence of the schizoid problem in *Personality Structure and Human Interaction* (1961). It includes revised versions of earlier papers, and also much new material. In the first part, a description of the schizoid condition is given, in terms of relations to the external world, internal states of ego-disintegration and the dissociated and lost emotional heart of the total self. The second part reviews the theoretical development which makes it necessary to see manic-depressive problems in the light of the deeper and more subtle schizoid condition. Part 3 seeks to assess fully the importance of Winnicott's research, and part 4 explores the implications for psychotherapy of the study of the schizoid problem. Finally, in part 5, the review of theory is brought up to date with a chapter on 'the concept of psychodynamic science', and another comparing the theories of Hartmann, Melanie Klein, Fairbairn and Winnicott.

Conditioned Reflexes and Neuron Organization. By JERZY KONORSKI. New York and London: Hafner. 1968. Pp. xx + 277. \$11.00.

This book, originally published in 1948, has been reprinted in 1968. The author's purpose is to integrate Pavlov's data with that of Sherrington 'in the hope that this work will do something to bridge the gap between their respective achievements'.

Modern Perspectives in World Psychiatry, no. 2. Edited by JOHN G. HOWELLS. Edinburgh and London: Oliver & Boyd. 1968. Pp. xxvi + 787. £8.40.

The present volume, one of the 'Modern Perspectives in Psychiatry Series', contains chapters written by 26 distinguished authors in psychiatry. The volume, introduced by Lord Adrian, is divided into two sections – scientific and clinical.

The Understanding of Dreams. By RAYMOND DE BECKER. London: Allen & Unwin. 1968. Pp. 432. £2.50.

The author believes that the most essential factor in dreams is that they include a rough plan of action and a means of approaching such action.

Beyond the Therapeutic Community. By MAXWELL JONES. London and New Haven: Yale University Press. 1968. Pp. xxii + 150. £2.90, \$5.75.

Dr Jones gives an account of the problems encountered in setting up a therapeutic community. He suggests solutions to many of these problems, and shows how the social structure of a hospital intimately affects the calibre and success of treatment.

Psychiatry in Transition 1966–1967. Edited by ALDWYN B. STOKES. (Clarke Institute of Psychiatry Monograph Series.) Toronto: Toronto University Press; London: Oxford University Press. 1968. Pp. xi + 137. £2.85.

This is the first volume of a monograph series published on behalf of the Clarke Institute of Psychiatry. The papers were delivered at the opening of the Institute, and together offer a picture of present-day psychiatric problems and trends ranging through the issues of psychiatric services, education and research.

The Overt Homosexual. By CHARLES W. SOCARIDES. New York: Grune & Stratton. 1968. Pp. 245. \$7.75.

This work attempts to cover the entire range of the disorders of homosexuality, including both male and female homosexuality. Theoretical con-

siderations, clinical psychoanalytic case histories, therapy and causation are discussed.

Interaction in Families. By ELLIOTT G. MISHLER AND NANCY E. WAXLER. New York and London: Wiley. 1968. Pp. x + 436. £5.50.

This work reports an experimental study investigating families with normal children as contrasted with those having schizophrenic children. The purposes of the study are to develop experimental techniques appropriate for the investigation of interaction in natural groups, and to investigate a problem posed in clinical psychiatric reports, i.e. the extent to which family patterns are related to the occurrence of schizophrenia in a child.

Mental Hygiene. By ISAAC RAY. New York and London: Hafner. 1968. Pp. xi + 338. \$10.50.

This is a facsimile of the 1863 edition, with a new introduction by Dr Frank J. Curran. It is published under the auspices of the Library of the New York Academy of Medicine.

Analytical Psychology: Its Theory and Practice. By C. G. JUNG. London: Routledge & Kegan Paul. 1968. Pp. xix + 224. £1.50.

This is an introduction to the ideas on which Jung's work was based. In 1935 he was invited to give a course of lectures at the Tavistock Clinic. He dealt mainly with the principles upon which his own contributions to psychology rested, presenting them under two main headings: the structure and content of the mind, and the methods used in its investigation. The lectures and succeeding discussions were recorded, and are now published, for the first time, in book form.

The Young Handicapped Child. By AGATHA H. BOWLEY AND LESLIE GARDNER. Edinburgh and London: Livingstone. 1969. Pp. x + 167. £1.50.

This is a second edition of a book published in 1957. The increase in our knowledge since the first edition has been integrated into the new edition. It provides useful educational guidance for the young cerebral palsied, deaf, blind and autistic child.

An Approach to Community Mental Health. By GERALD CAPLAN. London: Tavistock Publications. 1969. Pp. ix + 262. £1.05. (Social Science paperback.)

This book presents an account of the systematic approach to the prevention of mental disorder developed by the author and his co-workers at Harvard Medical School. A strategy is proposed for planning a community programme of primary prevention. This involves both inducing change by administrative action and affecting individuals in crisis either by the direct intervention of the mental health specialists or through the mediation of 'caretaking' agents such as doctors, nurses, teachers and clergymen. The theoretical basis of preventive intervention is discussed, examples of dealing with crisis situations are given, and the roles of various caretaking agencies are examined.

Psychiatry. Part I: The Anatomy, Physiology, and Chemistry of the Brain. By THEODOR MEYNERT. New York and London: Hafner. 1968. Pp. xi + 285. \$13.50.

This is a facsimile of the 1885 edition, with a new introduction by Dr Stanley W. Jackson. It is published under the auspices of the Library of the New York Academy of Medicine.

Basic Psychiatry. By MYRE SIM AND E. B. GORDON. Edinburgh and London: Livingstone. 1968. Pp. viii + 262. £1.25.

This small volume is intended to meet the need for a book which would deal with the subject of psychiatry in a manner generally adopted in teaching, i.e. that of question and answer. It is intended not only for medical students, but for nurses, occupational therapists, social workers, psychologists and others.

The Doctor, His Patient and the Illness. By MICHAEL BALINT. London: Pitman. 1968. Pp. xii + 395. £1.50.

This valuable and well-known book is now available as a paperback. The new edition contains some revision of the text, with some ambiguities removed.

Body Image and Personality. By S. FISHER AND S. E. CLEVELAND. New York: Dover Publications; London: Constable. 1968. Pp. xi + 448. £1.42½.

This is a paperback edition of the well-known book, first published in 1958.

Modern Psychoanalysis of the Schizophrenic Patient. By HYMAN SPOTNITZ. New York and London: Grune & Stratton. 1969. Pp. vi + 234. \$7.55.

This book is written as an account of the application of the general principles of the psychoanalytic method to the management of ambulatory cases of schizophrenia. The book is intended to contribute to the development of a systematic approach to the therapy of the preoedipal disorders and to the establishment of a sound theoretical basis for extensions of the basic model technique.

The Nature of Childhood Autism. By GERALD O'GORMAN. London: Butterworth. 1967. Pp. vii + 134. £1.50.

This little book deals with the problem of the definition of the term 'childhood autism'. It goes on to consider childhood schizophrenia, defence mechanisms against intolerable reality, the aetiology, symptoms and nature of autism, the pseudo-schizophrenic syndromes, and treatment, education and training.

Year Book of Psychiatry and Applied Mental Health 1970. Edited by S. B. WORTIS *et al.* Chicago: Year Book Medical Publishers. 1970. Pp. 558. £5.60.

The Year Book of Neurology and Neurosurgery, published in 1969, has given birth to a number of separate volumes devoted to the specialties which had previously been included in one Year Book. The present book is therefore, in a sense, a new venture.

Behaviour Therapy in Clinical Psychiatry. By V. MEYER AND EDWARD S. CHESSER. Harmondsworth: Penguin Books. 1970. Pp. 288. £0.75.

The authors describe the principles of conditioning and learning, and consider the relation between the current practice in behaviour therapy and those principles. The authors have written a full account of 'the state of the art', and have provided a succinct description of behaviour therapy.

A Manual of Psychological Medicine. By J. C. BUCKNILL AND D. H. TUKE. New York and London: Hafner. 1968. Pp. 536. \$14.50.

This is a facsimile of the 1858 edition, with a new introduction by Francis J. Braceland. It is published under the auspices of the Library of the New York Academy of Medicine.

A Glossary of Psychoanalytic Terms and Concepts. Second edition. Edited by B. E. MOORE AND B. D. FINE. New York: American Psychoanalytic Association. 1968. Pp. 102. \$3.25.

This is a revised edition of the highly successful glossary published by the American Psychoanalytic Association. It is a brief compendium of major psychoanalytic concepts and frequently encountered terms, and an index is provided for those terms not separately defined.

The Psychology of Anxiety. By EUGENE E. LEVITT. London: Staples Press. 1968. Pp. 259. £1.80.

This book attempts to give a sober introduction to what we know about anxiety. It deals with the terminology of anxiety, theories of the basis of anxiety, defences against anxiety, the experimental measurement of anxiety, the physiology of anxiety, and such various areas as the relation between anxiety and learning, cognitive processes, personality and everyday life.

Contexts of Education. By J. F. MORRIS AND E. A. LUNZER. London: Staples Press. 1969. Pp. xiv + 312. £3.50.

This book is concerned with individual differences in the learner, beginning with a discussion of intelligence and the assessment of human abilities. Further chapters deal with the assessment of personality traits, personality and adjustments, handicaps in learning, and the relation between the environment and the learner.

Short History of Psychiatry. By ERWIN H. ACKERKNECHT. (Translated by Dr Sula Wolff.) New York: Hafner. 1968. Pp. xii + 109. \$4.25.

This is the second edition of the successful first edition, which appeared in 1959.

Lectures on Clinical Psychiatry. By EMIL KRAEPELIN. (Authorized translation from the German, revised and edited by Thomas Johnstone.) New York and London: Hafner. 1968. Pp. xv + 308. \$12.50.

This is a facsimile of the 1904 edition, with a new introduction by Dr Oskar Diethelm. It is published under the auspices of the Library of the New York Academy of Medicine.

Clinical Psychology as Science and Profession: A Forty-Year Odyssey. By DAVID SHAKOW. Chicago: Aldine. 1969. Pp. x + 350. \$12.50.

This volume brings together for the first time the most significant papers of Dr Shakow in the area of clinical psychology. It presents a comprehensive, far-reaching overview of clinical psychology addressed to all of its professionals and students. It pays special attention to the history and functions of clinical psychology, training objectives and programmes, liaison with other professions, relationship with psychoanalysis and commitment to public service.

The Classification of Depressive Illnesses. By R. E. KENDELL. London: Oxford University Press. 1968. Pp. 102. £2.00. (Maudsley Monographs no. 18.)

This book presents a discussion of the classification of depressions, as well as the results of a statistical and factor analytical study based on the Institute of Psychiatry item sheet.

Decision Making and Age. Interdisciplinary Topics in Gerontology, volume 4. Edited by A. T. WELFORD AND J. E. BIRREN. Basel and New York: Karger. 1969. Pp. viii + 166. £4.40. (Distributed in U.K. by Academic Press.)

This publication contains papers presented at a NATO sponsored conference on 'Decision Making and Age' held in Greece in August 1967. It

attempts, in an important sense, to bridge the communications gap between basic and applied science. The present volume deals with the application of basic information and techniques in an analysis of processes involved in decision making, and how these change with age.

Insight Therapy. By TIBOR AGOSTON. Ohio: Columbus Blank Book Co. 1969. Pp. 334.

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Reflexions on past and present events*

BY WILLIAM P. KRAEMER†

On 30 January 1971 it will be 38 years since Hitler assumed power in Germany. His rise and fall were dramatic; his rule threw Germany and the world into one of the greatest cataclysms in history, and one which decisively changed its course.

Millions of words have been spoken, thousands of books and articles written in an attempt to seek a better understanding of the great catastrophe. Films, plays, lectures and pronouncements have been made on the subject, and there seems as yet no end to the ardent collective endeavour of finding out the truth. My reflexions tonight, however, are not merely concerned with Hitler and other evil-doers of the Third Reich; but while the events of the last five or six decades – that is, those of my own life – will present the background of my talk, its object is that of furthering the cause of psychodynamic principles by once more looking at the German mass movement from an analytical viewpoint and thereby adding my own contribution to the understanding of collective as well as individual man. This has been done by many other politico-psychological observers before, and some of them, like C. G. Jung (1947, 1968), H. G. Baynes (1941), Bruno Bettelheim (1960, 1969) and Alexander & Margarete Mitscherlich (1968), have made contributions of such outstanding quality that I have for some time hesitated to voice my own thoughts and feelings about a subject to which men and women of their distinction had already given such close attention. Equally, as many eminent British and American authors such as Dicks (1947, 1966), Gilbert (1947, 1950) and Rees (1947) – to name but a few – have published

work based on knowledge which was acquired through their own investigations of major war criminals and through personal acquaintance with other *dramatis personae* of the recent historical scene, it had again and again seemed presumptuous for me, who possessed no such detailed knowledge, to make pronouncements referring to politico-psychological concepts.

My urge to do so, however, has grown rather than lessened over the years, and what in post-war German vernacular is known as 'die unbewältigte Vergangenheit' – for obvious reasons untranslatable in its true connotation but meaning approximately 'the un-integrated past', the past, that is, which has not yet been atoned – this has proved to have such a strong hold over me that I at last overcame my doubts and decided to appear before this audience to make my reflexions known. It was a decision also based on self-interest, as I hoped to clarify my own inner situation for myself by having to write these notes which, incidentally, do not deserve to be called a paper in the accepted sense of the word, for which shortcoming I can only crave your indulgence. I have certainly rarely in my life been more desirous to talk about anything than I am now to talk to you about this theme which, I cannot help feeling, has chosen me rather than the reverse; but paraphrasing Freud (1954) in his letters to Fliess: I had to wait until it moved in me so that I could perceive – and, I add, more adequately express – it.

One of the reasons why I may have the right to speak is that I am in a somewhat special position. So are we all of course; but I mean something quite specific which I want to make clear before I proceed any further, and this concerns my personal background and upbringing. There are many different degrees as well as different kinds of psycho-

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logical involvement in historical events, and mine was of a fairly high degree and of a rather unusual kind. For example: I have mentioned Jung and Bettelheim. The former was a German-speaking Swiss, in Nazi language an Aryan, the other an Austrian Jew. Jung, though deeply interested and no mere observer of German events, was yet an on-looker due to his Swiss nationality. Bettelheim, although like all Austrians much more involved in what was going on in the brotherland, also remained *to some extent* an on-looker until the German take-over. Baynes speaks of a 'gulf dividing those within the [German] experience from those without', and the Mitscherlichs and I myself were certainly of the former group, i.e. Germans born and bred within the confines of the Reich. But while the Mitscherlichs were to remain in Germany throughout the Hitler period I emigrated in 1933 and was thus bound to experience the drama of the Third Reich, though hardly less affected than they were, yet from a decisively different angle. I was brought up in French-occupied territory where hatred of the occupying troops belonged to my early lessons as much as anything else I learned. Though we lived in the Prussian Rhenish Province, my parents were much more Prussian than Westerners in feeling, and therefore thought it essential that their children should be educated in the Prussian capital rather than remain exposed to possible French contagion in Rhenish schools. Hence we were duly despatched to an ultra-nationalistic and, incidentally, otherwise very modern and free boarding school in Berlin where, however, no Jews were admitted, although among the non-boarders – the oppidans, so to speak – there were a number of Jewish boys. The fact that some of my own forebears were of Jewish descent was never discussed and was certainly not known to me until much later, and while my family cannot be described as antisemitic in outlook, Jews were nevertheless regarded as belonging to an alien background.

My early memories during the 1914–18 war had been of imperial and royal might and

splendour. Pictures of the Kaiser and his family remained objects of veneration even after the 1918 revolution, and both at home and later at school royalist attitudes were taken for granted, and His Majesty's birthday, for instance, which happens to be today, 27 January, would always be remembered by all of us. Certainly more so than Mozart's birthday on the same date.

I do not know how typical we were of German children at that time, but the fact is that we ourselves lived in a political world and played political games from as far back as I can remember, with emperors being crowned, murdered or born as the case might be, kings deposed and nations vanquished. This happened even before and during the 1914 war when Germany was threatened by the attack of ruthless enemies, for until 1918 Germany not only had an emperor who was Prussia's king, but in addition three more kings and about 20 ruling grand-dukes, dukes and other reigning princes as well. Thus our later childhood stood under the shadow of deprivation, and the loss of all this power and glory found its compensation in our continuous, acted-out phantasies by which we once more created a most complex hierarchy of rulers and royalty, just as Napoleon had done as a young man when he played around with the thrones of Europe. In that way the Sleeping Emperor of pagan folklore, later based on Frederick I of the Holy Roman Empire or even the Franco-German Charlemagne, was reawakened in the experiences of our own nursery, which in their turn seemed to be strangely and omnipotently reflected in such outer events as Hitler's *Putsch*.

Thus when Ludendorff and Hitler failed in their attempt to seize power in Bavaria in 1923 – the year of the worst French terror in the Rhineland – we children, like the rest of the family, were deeply aggrieved, and Hitler remained a hero in our inner world.

Although my father and our teachers now served the Weimar Republic they made no secret of their lasting attachment to the Royal House of Hohenzollern, and their oath of

allegiance as officials of the Republic was explained away by the generally accepted necessity that – and this was the exact wording – ‘one must not shrink even from *perjury* if it is done for the King’. The President of the German Reich, the Imperial Field Marshal von Beneckendorff und von Hindenburg, set a venerable example for the ethical rightness of this attitude, and even till the end of his life and when Hitler had already become his Chancellor he professed that he never made any decision without first thinking of what his Imperial Master, then living in exile in Holland, would have wanted him to decide. It would indeed be tempting to speculate about the Kaiser’s own attitudes on some of the issues involved – and among conflicting reports is Lady Norah Bentinck’s (1921) story that she found the Emperor utterly convinced that his fall was due to the Jewish world conspiracy when she visited him in 1921 – a story totally discredited by one of the Kaiser’s personal friends and a frequent visitor to Doorn, my colleague Baroness von der Heydt (private communication, 1970). But whatever these attitudes may have been, suffice it to say that patriarchy was endemic and remained so in Germany even after 1918. Wangh (1964), one of the best-informed writers on the subject, rightly stresses the confusion – so vividly described by the German nationalist Ernst von Salomon (1930), the man co-responsible for Rathenau’s murder – which existed in young Germans of the post-World War I generation. They had been deprived of their father-figure represented by the King-Emperor, who had been removed by the socialist parties, and were thereby in acute danger of losing one of the corner-stones of a structure on which their collective identity had been built. To counteract this danger the Emperor’s disappearance from the German scene had to be given an effective interpretation which would serve the need for a defensive denial of reality. As it was not possible to deny the *fact* that he was no longer in authority, this had to be understood in such a way as would maintain the integrity of the system which he had

personified. In order to survive, a myth created itself in the national collective which was called ‘*der Dolchstoß im Rücken*’, ‘the stab in the back’. According to this, the German armies and their Imperial Supreme Commander had never been defeated in the field of battle, however unchivalrous and inhuman a warfare the Allies had waged against them; the inglorious end of the war had been brought about solely by treachery at home where the socialists – at all times stooges of international Jewry – had seized power, while good brave German men were away fighting for the country’s survival. And while their backs were turned this despicable clique of traitors had callously surrendered to the enemy.

Thus our honour had been preserved, and when I was a boy – and long before Hitler came to power – we learnt certain words addressed to the dead soldiers of the war, words which were later written on many a war memorial in German towns and villages and which read: ‘*Ihr habt doch gesiegt*’ – ‘And yet you *were* victorious’. Ernst Jünger’s (1922) immensely popular book gives powerful expression to this widespread attitude, and the long columns of retreating soldiers still under the leadership of the same Imperial Field Marshal who was eventually destined to become the President of the Republic did indeed march in perfect formation over the bridges of the Rhine, with their flags flying high in the wind and their bands playing once more the traditional martial tunes. They carried flowers and waved to enthusiastic crowds and especially, it seemed, to us children who stood day and night near the roads and bridges to welcome them. They returned like victors, and the myth appeared as undeniable truth.

Incidentally, this same denial of the reality of defeat by Hitler in 1945 is most vividly described by Albert Speer (1969), who found the Führer’s firm belief in his coming victory so convincing that he was swayed into a state of exalted optimism even a few months before the final débâcle. Equally Napoleon wrote

letters of unbelievable confidence to his wife as late as a week or two before his enforced abdication in the spring of 1814 (Palmstierna, 1958). I must admit though that my terrified foreign eyes saw the British people too display this same lack of realism in 1940 when the man in the street continued to believe in a future victory, a belief entirely based on a collective myth of invincibility and in no other way justifiable.

Anyway, due to their psychological inability to admit defeat and to feel inferior, weak and guilty, the Germans had to project all those characteristics which did not correspond to their own highly idealized image on to somebody else. While they themselves were the custodians of the myth, or even personified it in their collective, others had to become the representatives of the evil which they denied in themselves. The tremendous force of the need to deny evil in one's own person can be observed in children and adults of all ages and nationalities, and it expresses itself in a great variety of aggressive behaviour. That this human characteristic eventually led to horrific and totally pathological dimensions in the case of the German nation under Hitler's rule cannot be doubted, though the reason why this happened is not at first self-evident. Wangh postulates that the militant young men who had carried Hitler to power were conditioned by collective childhood experiences. I quote: '...these youthful followers of the Nazi movement reacted regressively to the fear produced by the economic depression of 1930 because their childhood years were encompassed by the First World War and its aftermath'. He mentions that the psychological effect of the father's prolonged absence and his defeat as a soldier (though perhaps never quite admitted), his failure to protect the family from economic misery and the continuous and heightened anxiety of the mother throughout this time, 're-evoked in these young followers a previous anxiety, experienced in childhood...', in fact, 'the economic and social stresses of 1930 to 1933 re-awakened in the youth of this generation the anxiety

previously experienced in the years 1917 to 1920...'. Wangh reminds us that these militant young Nazis were to a large extent members of the lower middle class, and this is indeed significant. For their economic vulnerability combined with the particular consciousness of social status that is inherent in this class makes poverty and hunger appear doubly threatening to them. Furthermore Hitler, himself the personification of the *petite bourgeoisie*, had been through very similar experiences.

He did not, however, belong to their age-group, and though Wangh makes no specific mention of Hitler's age, the emphasis he puts on the ambivalent relationship of the father-deprived small boy towards the returning father and the regressive propensities of such a child, both before and after the father's homecoming, makes the idealization of Hitler as the unconsciously despised and consciously worshipped father doubly plausible. Wangh observes:

If it is not easy to cede one's place next to mother even to a victorious returning father, how much more difficult it is when the father does not appear to deserve this renunciation! Defeat [after all], starvation, revolution, inflation – all these served only to prove to the son of the lower middle class that his so emphatically autocratic father was incapable of protecting the family.

As an analytical psychologist I want to make an important addendum here, which is that the absence or diminution of the personal father is apt to create a psychological vacuum which can all too easily be filled by an archetypal father image, incarnated as it were by a heroic figure. All this would certainly also apply to Hitler himself, the Austrian volunteer in the defeated German army.

Furthermore, although never a *father* in the biological sense of the word, Kubizek (1953) leaves us in no doubt regarding Hitler's extremely autocratic nature and behaviour even as a young man in his Linz and Vienna days.

My own postulate therefore is that Hitler not only ganged up with those young militants and made himself into a mouth-piece of a

deprived generation, but that he also played the role of their father and thus became a natural target of the oedipal dilemma. The existence of a continuing ambivalence towards the person of the Führer even among his enthusiastic followers was in fact easy to detect both before and after his assumption of power. During the years of my Italian exile between 1933 and 1938 I frequently returned to Germany in order to visit my family. My father was then Deputy Head of Public Prosecution in the provincial capital and as such was in close official and social contact with leading members of the Party, some of whom I got to know quite well. I remember distinctly that at some social gatherings several of these people, presuming that owing to my prolonged absence abroad I might not be familiar with the imponderabilia of the German scene, took it upon themselves to give me friendly advice. Its essence was remarkably uniform and consisted in short of a warning not to tell any funny stories relating to Hitler's person, who was thus given archetypal status like Caesar Augustus, the God, while *Mözkes* – the Rhenish word for jokes – about Goering, Goebbels or the Nazi Party as a whole would be perfectly admissible. They made it abundantly clear, however, that the Führer was commonly regarded as a somewhat queer fellow by his more intimate entourage who, out of loyalty and by unspoken consent, must continue to uphold his public image. Even at that time such an attitude reminded me of the ambivalent feelings that sons traditionally have towards their fathers: 'He may be despicable but still – he is our father and we had better try to honour him.' Albert Speer, perhaps Hitler's closest colleague during the war years, in fact describes his feelings about the events of 1933 and 1934 by simply stating that 'doubts that could have disturbed us were repressed'.

Erikson (1949) incidentally maintains that Hitler never even aspired to become a father in any connotation... He is the Führer: the glorified older brother, who replaces the father... a gang leader

who keeps the boys together by demanding their admiration, by creating terror, and by shrewdly involving them in crimes...

I now want to return to the theme of the projection of evil in a more pertinent way. As has already been mentioned, the burden of guilt and shame after the 1918 defeat proved too much to be borne, and scapegoats had to be found. The most obvious choice would have been the Allies who had caused the downfall of the Reich, but they were of course not within physical reach and due to their military power no act of revenge could be contemplated as far as they were concerned. Furthermore, since the Treaty of Locarno in 1925 the former enmity between Germany and her Western neighbours had given way to a spirit of reconciliation between the Governments, and bygones had been allowed to be bygones. In 1930, at the time of the economic depression which was destined to bring Hitler to power three years later, it would have been something of an anachronism to direct German hatred once more against the nations who had vanquished her 12 years earlier. Yet with the renewal of disaster the urge to look for those responsible for the original defeat again became paramount.

For hundreds of years the Jews had been chosen by many nations and under the most diverse circumstances to play the role of scapegoats whenever such were needed. In Germany as in other lands antisemitism had been endemic throughout her history. Though the ghettos had been abolished in the 18th and 19th centuries, Jews were still regarded, and often regarded themselves, as an alien people. Although they had gradually been more accepted and given greater freedom, many professions were still closed to adherents of the Jewish faith in Germany. They none the less began to play an important part in pre-First World War Germany, and those who had left their religious communities eventually ceased to be regarded as aliens and became more fully integrated in the life of the nation. All the same it must be remembered that the myth of the Jewish world conspiracy – which

according to Cohn (1970) represents a modern adaptation of the ancient tradition that Jews were demons in human form – had been abroad for many generations. As early as 1806 the French Revolution and the rise of Napoleon were claimed to be due to Jewish conspiracy, while more than a century later the London *Times* (8 May 1920, p. 15) commented anxiously on this same theme by asking: 'Have we, by straining every fibre of our national body, escaped a "Pax Germanica" only to fall into a "Pax Judaeica"?' The Jewish menace was indeed felt by many different people at different times to be an unquestionable reality.

In the 1918 Revolution several Jews were in fact prominent among the more radical leaders, just as had happened in the Russian Revolution a year before. Others, however, like Albert Ballin, a personal friend of the German Emperor, had in patriotic fervour committed suicide when the war was lost. During the Weimar Republic, as before, Jews continued to lead peaceful and ordinary lives, and, depending on their own assessment as Jews and Germans, the degree of their assimilation varied from individual to individual. Equally, some belonged to the political left, others to the right, some also were German chauvinists or radical internationalists. In fact there was now very little that made them outwardly different from anybody else.

Why it was nevertheless the Jews who were yet once more singled out as the culprits is not surprising if one remembers the particular role that God seemed to play in the Old Testament. In what I am about to say I am going to be deliberately subjective and naive, but I hope it will not sound irreverent. I shall recall to the best of my knowledge the kind of impact the presentation of the Old Testament made on me when I first went to school. My divinity masters were, incidentally, all evangelically inclined and whatever their political opinions may have been, there can be no doubt whatsoever about their acceptance of the whole Bible, including the Old Testament, as a holy book. They were – at least as far as they

consciously knew – entirely convinced of its revelational nature. From many conversations which I had with other boys of my own as well as of other German schools – at that time and at later dates – I have gained the impression that my own feelings about the God we were taught to believe in were shared by the majority. I suggest that Hitler – though a Catholic – and many other National Socialists may have had similar experiences.

Not only was God a revengeful, authoritarian and rigid father, he was also intensely nationalistic and narrow in outlook. The Jewish people were the only ones worth bothering about, hence he was always on their side in battle and let them win most wars. God had a long white beard and looked venerable. Some of his servants and special favourites looked a little like him, though they were smaller in stature. This was especially true of Abraham, Isaac and Jacob, who in German were invariably referred to as *die Erzväter* (the primal fathers). Jacob was originally not a very nice character and stole his elder brother's inheritance of love, but the end justified the means, and anyway God was not really interested in the elder brother because in some mysterious way he was less of a Jew than was Jacob, who in due course became the leader of his nation.

If this was in fact what God and his Jewish people were like it strikes me that the Nazis – regressed like primary schoolboys as they were – had a very similar mentality. By and large, if you substitute 'German' for 'Jew', you are not so very far from Streicher's level, and in any case what better object to project on exists than that with which one is unconsciously identified? Baynes in fact suggests that

there is an obvious implication here which might well have been a major incentive in the Nazi persecution of the Jews, since within the precincts of a single national faith there cannot be two absolute deities, still less two Chosen People.

I myself remember very clearly how puzzled I was by the doctrine of the Chosen People.

Were they the Germans, as we were taught most of the time, or were they the Jews? It made no sense to me.

It is particularly important to recognize the strong emphasis on fatherhood, that of God as well as of the biblical fathers, which played such an enormous role in the religious instruction of the German children of that generation, and I submit that all the oedipal ambivalence regarding the authoritarian father on earth was also operative in the attitude towards God and his Jewish people. Erikson (1959) speaks of the young Luther's experience of 'God in the role of the dreaded and untrustworthy father', while in Erikson's words he later was 'the metaphysical jurist of his father's class' and in my own view became identified with Moses' commandment 'Honour thy father' to an almost diabolical degree (the reversal of his compulsive enmity against the Pope). Thus as children together with the Ten Commandments we had to learn Luther's explanations of each of them. I have forgotten most of these but significantly I remember the first words pertaining to the First Commandment. These words were: 'We must *fear and love* God.' Hitler, who later was to tell Rauschning (1940) that the Ten Commandments had lost their validity, was, I repeat, not a Protestant nor had he indeed to suffer to the same extent from a brutal personal father as had Luther, but, as Erikson quoting Kubizek reminds us, 'was also subject to an occasional "good hiding" by his father' who combined the petty authoritarianism of a small official with a general shiftlessness and an inclination towards adultery, alcohol, and brutality...'. What Hitler himself writes about his father in *Mein Kampf* (1925) is not overtly disrespectful, but his embittered passages about the *bourgeoisie* to which his father had so laboriously worked himself up from humble beginnings speak for themselves, and the parental pressure aimed at making the son into a little Austrian official on the father's model were frantically resisted by the 11-year-old Adolf. Though Jetzinger (1956) claims fairly convincingly that no such pres-

sure was ever exerted and that Hitler's own account of this is a complete fabrication, it throws a significant light on his inner experience of oedipal conflict.

Of parallel importance in this connexion are Hitler's relationships to his mother and other female members of his family. Waite's (1966) richly documented study leaves us in no doubt that his half-sister Angela, and even more her daughter Geli, were the objects of his enduring love. His parents themselves were – at least officially – second cousins once removed, and the father continued to call Adolf's mother 'niece' all through their married life. Hitler's feelings for her were strong and genuine, and after her death only Angela and Geli played a comparable role as love objects in his inner world. When Geli committed suicide under mysterious circumstances, but apparently for reasons connected with her relationship to Hitler, he was thrown into one of the greatest crises of his life. As it is almost certain that Hitler never had normal relations with any woman (or for that matter with any man) it is likely that he continued to exist in a completely unresolved oedipal position in which potential love objects are unconsciously chosen from among a group of women (i.e. mother and mother substitutes) to whom the incestual taboo – though not necessarily legally – yet essentially applies.

We can now turn again to the Jewish problem. I am quite convinced that Waite and Jetzinger are right when they see in Hitler's preoccupation with the identity of his paternal grandfather a proof of his fear that he may have had Jewish blood, and Baynes mentions even the possibility that Hitler's father could have been a Jew, which, though historically absurd, is a symbolically valid and ingenious phantasy. However, in view of the facts, his preoccupation would not be surprising, though his fear may well have been unfounded. It consciously stemmed from the illegitimacy of his father, who was adopted by a man called Schicklgruber, whom the father's mother married when Hitler's father was five years old. A Jewish family where the later Frau

Schicklgruber had been a housemaid gave financial support to her after Adolf's father was born. The official version was that the man Schicklgruber had not only legitimized but also begotten the child, but no documents have ever been found to verify this, and the Jewish family's proved interest was bound to leave a sting of doubt in Hitler's mind. In the oedipal conflict situation this sting assumes particular importance. In passing it should be mentioned that some of Hitler's most fanatical and brutal followers also were what in Germany was called 'Putativ-Juden', i.e. people who believed themselves and feared to be of partially or wholly Jewish descent. Heydrich, for instance, was called 'Isi' (i.e. 'little Jew-boy') at his school in Halle and mercilessly teased by his school-mates. One of them, a Dr Schultze (1970), witness at a recent court case in Berlin, stated that Heydrich had felt greatly exasperated (and obviously been very impressed) by this and later had wanted to show his mettle to Hitler and Himmler by perpetrating the mass killings of the Jews.

In *Mein Kampf* Hitler's doubt is, of course, in no way alluded to, but instead the author gives a vivid, naively idealized account of the beginnings of his antisemitism. He describes how in 1910 he was walking through the streets of Vienna (as we know, a very disappointed, embittered and frustrated failure of a man) when he suddenly saw a Jew in his caftan and with black curls. Some kind of visionary certainty of the evil of Jewry then descended on him and henceforth he identified this race with the source of all badness and misery that existed in the world.

Although this dramatization of Hitler's must be taken *cum grano salis* because we now know that Hitler had in actual fact already been closely connected with militant antisemitism for years, I postulate that the violence of this so-called conversion is of an oedipal character and that everything that I have mentioned earlier in this connexion was amalgamated into the Nazi pseudo-dogma which was to conquer Germany in later years. It succeeded because the oedipal conflict is

universal, and the Jews were its externalized object of hatred because, as Grunberger (1964) points out:

Judaism presents itself as above all a worship of the Father, a severe, omnipresent, omniscient father, an implacable judge. . . For the worship of the father is not limited to reactivating the Oedipus conflict, which is as old as mankind, but in addition has interiorized the punitive element and as such has presented humanity with something it is not prepared to forgive.

He continues:

the innovation presented by Jewish monotheism consisted not only in institutionalizing a superego sanctified by religion which favoured the repression of oedipal guilt, but also the transformation of that partly conscious guilt into deeply buried guilt.

Cohn strikes the same note when he maintains that the demonized Jew

is unconsciously seen as a cruel, tyrannical father-figure. . . ideally situated to receive the unconscious negative projection associated with the 'bad' parent, and particularly the 'bad' father;

indeed in the act of crucifying Christ becoming even the slayer of the son. But Cohn adds that Jews, having become prominent in the modern world as innovators, radicals and revolutionaries, are simultaneously seen as collective *bad sons*, demons and destroyers of order and authority, just as they had behaved like bad sons before, by rejecting Christianity. Yet here Erikson's (1970) shrewd comment on modern youth comes to mind when he observes that 'parricide remains a much more plausible explanation of the world's ills than does filicide'. Lowenfeld (1964), commenting on Grunberger's and Wangh's studies, remarks that 'people can be manipulated, if the people in power have the gift of understanding the hidden emotional needs of men'. Hitler, who in Baynes's words tuned in to the racial unconscious, certainly also understood the need that existed in Germany at the crucial time of his disastrous

rise to power. As Rauschning, himself a former Nazi, put it in 1940:

For all those who had been unsuccessful in the battle of life National Socialism is the great worker of magic. And Hitler himself is the first of these. Thus he has become the master-enchanter and high priest of the religious mysteries of Nazidom.

It is obvious to me, however, that the seduction of Germany by Hitler must, like most seductions, be seen as a reciprocal phenomenon in that Germany also seduced the Führer and continued to do so. The enormity of this mutual seduction is more eloquently described in his memoirs by Albert Speer than it had ever been before.

There is a further thought which would seem to support the oedipal thesis. The Nazi Jew-baiter of course constantly raged against those who debased themselves by having sexual dealings with Jews or Jewesses. They and their Jewish accomplices were described as vile, debauched and corrupted, and in 1935 what was called 'race defilement' became a punishable crime. An extraordinary, and to my mind highly significant, aspect of the violent vituperations directed against the culprits of such crimes is that they were usually referred to by a hyphenated word: *Blut- und Rassenschänder*. The latter was of course a completely new concept and meant 'racial defiler'. The word *Blutschande*, on the other hand, is old and simply means 'incest'. I think I have made my point.

I should like to end this part of my talk with a few quotations from Gilbert (1950), Jung (1936) and Baynes (1941) which seem to be particularly apt. Of the Nazi movement Gilbert says:

The avowed purposes of the movement were to be daringly progressive and revolutionary, but the underlying psychology was regressive and counter-revolutionary... Prejudices, religious beliefs, national and ethnic myths exist in every society... Such group attitudes might be considered 'latent paranoia', which is universally present... A state whose leader suffers from true paranoid tendencies... channels that paranoia into the political

ideology of the state [which] has direct resemblance to behaviour prompted by systemized delusions.

In fact, Gilbert maintains that while 'Hess and Streicher like Hitler had channelled their paranoid tendencies into the political ideology... the rest of the hierarchy [merely] behaved as if they did share these delusions.'

Here are some of Jung's observations made in 1936: 'Wherever the mass begins to move instead of the individual, human ordering ceases, and the archetypes begin to operate.' And: 'From time immemorial it has been a terrible thing to fall into the hands of the living God.' This I could in fact have chosen as a motto for this paper.

And finally Baynes: 'There was a numinous flame, a compelling sacrament of power which had taken possession of German youth, and Hitler responded to it.' Baynes was a very shrewd observer whose book on Germany, he wrote to me in 1942, had not really been accepted in Britain. While in my view he had a deep understanding of certain events in Germany I do not always agree with his interpretations. For example, I maintain that the anti-German pronouncements of Goethe, Heine, Hölderlin and Nietzsche cannot be seen in isolation but are in fact part of German self-hatred, as typical of Germans as is the Jewish self-hatred typical of the Jews.

I now want to turn my attention to the attitude of the post-World War II youth of Germany. Lowenfeld, writing in 1964, stresses 'the fact that the present generation of Germans has shown no ideological reactions comparable to those of the Hitler period, though they certainly went through the same or worse emotional deprivations in the oedipal period and much worse defeat'. My own experience of that generation bears this out in so far as *conscious* attitudes go. That is to say that only a small minority of German youngsters were still inclined towards National Socialism and still fewer expressed the particular romantic longings for the past which had been so widespread in the twenties and thirties when the Wandervogel movement had kept the tradi-

ional *Sturm und Drang* psychology alive, ready to be channelled into political alignments of the right or left. Laqueur (1962) reminds us that the charismatic Führer idea originally stems from this movement, and the present German youngsters certainly did not seem to be particularly attracted by such concepts. Nor indeed had they much use for what their parents had stood for in any other respect. Lowenfeld assumes 'that they turned in the typical adolescent way against... the... parental... Hitler generation, and may for this reason be immune to nationalistic excesses...'. Although this is ostensibly true, the situation appears to me very much less innocent than meets the eye, as I myself have detected much more violence in their collective attitude than can be ascribed to and described as a simple change of heart. The young Germans whom I have met and whose articles and letters I have read in the press have often struck me as rather prejudiced people who tend towards political radicalism though at present of the left rather than the right. Thus they frequently denounce their government, their schools and universities, the police and other representatives of the establishment with such vehemence and bitterness as is hardly equalled by comparable phenomena even in the more recent behaviour among other Western adolescents. Particularly interesting also is a widespread and rather exaggerated pro-Semitism, so that the former attitude towards the Jews appears to have turned to its very opposite. During the Six Day War, German youths demonstrated their pro-Israeli sympathies in a more violent way than was the case in any other country of the West, and reversing Hitler's attitude, everything Jewish was good and valuable, while the Arab cause got little or no hearing. In the same way a great deal of anti-nationalism was furiously and often indiscriminately expressed, and when I once dared to remind some German student that our nation had not only produced a Hitler, but also Goethe, Beethoven, Mozart and other great men, I got a rather cool reception. Baynes (1941) pro-

phetically wrote this of the instability and one-sidedness of the German mentality: 'its tendency to swing over to the previously excluded antithesis with a suicidal abandon... only changes the position of the pieces on the board; it cures nothing'.

When I gave a talk about the background of Hitlerism to boys and their parents at my old school in Berlin a few years ago, one of the parents reflected afterwards that it was only due to my British passport that the boys had allowed me to speak objectively about these matters, while they would have shouted him down if he had dared to do so. This is another dangerous phenomenon: foreigners are regarded as superior to Germans, and my naturalized status as a Britisher gave me immunity on that and other occasions. This, by the way, I have even found to be true with regard to customs officials who at one instance were about to 'requisition' my six bottles of whisky at the frontier until I remembered in time to wave a magic British passport and made the customs men disappear amidst heel-clicking apologies.

The ambivalent oedipal attitude towards the patriarchal past, towards parents and indeed the Fatherland uses a wide spectrum of expression, and I know from my personal experiences of a life-time how equally flimsy German internationalism and patriotism are, and how easily extremists of either kind can go into the opposite camp. The English for one are fundamentally different in this respect. When I was a schoolboy in an English public school and, in the true German manner, much impressed by the authoritarian system I found there and which stood in such unbelievable contrast to the liberalism of my German school, I remarked to one of the boys that were I not German I would like to be English. His laconic answer was: 'If I were not I should like to be English.'

The militancy of German youth, their apparently spiritual hunger, whether pre- or post-Hitlerian, however, no longer stands in isolation. The last decade has seen the same phenomenon in other Western countries.

'Die grosse Abrechnung' ('the final settlement of accounts'), as Hitler called it when he screamed his threats at his political opponents in the Reichstag, his fists clenched and wrath pervading his whole being, this settlement is now sought by a furious crowd of young men and women almost everywhere. Hitler roused the masses to paroxysms of hysteria when he shouted his genocidal menace. 'An eye for an eye, a tooth for a tooth,' he cried, and promised to do such things to the Jews that they would no longer feel like laughing at him. (Laughing at archetypes is verboten.) He kept this promise, almost the only one he had ever kept, and not only the Jews stopped laughing. Everyone did. When I look at the paranoid events in our colleges and universities I am reminded of this sombre fact. Bettelheim (1969) remarks 'how persuasive paranoics can be in their unconscious appeal to the vague and fleeting paranoia of the immature and disgruntled'. He knew of a 'student activist who took part in every demonstration he could, because while they lasted they gave him a temporary feeling of "being close to others".' And Bettelheim continues:

To embrace the extreme position... can... be an ego defensive action. It succeeds because the discharge of rage and violence drains off the aggression that would otherwise destroy whatever paranoid defences remained working. Typical of such persons is the quasi- or openly delusional beliefs, their inaccessibility to reason while loudly complaining that nobody listens to them, the over-simplification of issues, and the pre-occupation with violence and destruction (the marginal destruction of themselves, and the readiness to consider the destruction of their enemies).

These are the leaders of 'the Confrontation that pits the world of the fathers against the world of the sons'. Bettelheim found 'most of them to be consumed by a self-hatred from which they try to escape by fighting any establishment'. This indeed is the present situation from Tokyo to New York and Washington, this is happening in Trafalgar

Square every weekend, in Berlin, Bonn and Rome. They march and shout for something, they cry and threaten and protest. The end of the Vietnam War will bring them no relief, just as the genocide of the Jews brought none to Hitler. They rebel against the archetypal fathers, be they *Erzväter* or American Presidents. It is the great oedipal rebellion which will continue ever more.

There are many apparent contradictions in all this however, and once more I shall return to autobiographical themes. I remember quite distinctly why I was so much attracted by figures like the Kaiser and Hitler (whom I do not really wish to mention in the same breath). The reason for my admiration was not just due to any latent indoctrination of my childhood, but it was much more because the Weimar Republic with its facile permissiveness and good-mannered liberalism was so intensely boring. Not being the slightest bit heroic by nature, I looked for heroes. Hegel's supposed attitude towards the Hohenzollern monarchy as a divinely chosen vessel was of course deeply echoed in the collective Prussian psyche, but the Kaiser remained my hero because he was idealized into the totally other unreality – other from myself and other from the pedestrian reality which I had to live. And so was Hitler. He promised exciting adventures and used big glittering words such as had fallen into disrepute in the civilized society where we lived. Also, as Burckhardt (1929) says in connexion with Luther's tendency for ever to be *against* something, Hitler like Luther and other revolutionaries was supported by those 'who [in joint dissent] would rather *not* have to do this or that any more'. Thus Hitler's revolutionary ideas sounded like magic promises which might do away with such irksome obligations as going to school, and working for exams of course.

Erikson's (1959, 1970) concept of a psychosocial moratorium is relevant in this context. It is described as 'a period when the young person can dramatize or at any rate experiment with patterns of behaviour which are both – or neither quite – infantile and adult,

and yet often find a grandiose alignment with traditional ideals or new ideological trends'. Thus was the case of German youth in the 1920s and 1930s and thus is the case today. Youth cries for Castro, Che Guevara and Mao Tse Tung. These are the heroes of the present. 'Ho Chi Minh!' they shout, and instead of raising their hands in the Hitler salute as we did when we were children, they wave Mao's little red book. It does not matter that this book is about as boring as *Mein Kampf*. It is not there to be read but to threaten the establishment with, the 'System', as Hitler called it.

Why does nobody cry 'Brezhnev' and 'Kosygin'? I asked this question the other day when an orthodox Communist acquaintance talked to me about the blessings of the Communist regime in Russia. His answer was that the cult of the personality had been abandoned since Stalin's and Krushchev's days, and that it was the Communist *system*, not any particular personality, which now counted. He had indeed given me the right answer because Brezhnev and Kosygin had long ago become *establishment*, were no longer representatives of a living revolution and now formed an almost indistinguishable part of grey, everyday existence. This was true both from the Russian point of view and from that of international foreign politics. They negotiated with the Americans, they signed Westernized treaties. The fire had gone out and the light no longer burned. They were ordinary mortals, weak epigones of a heroic past, dutiful officials who no longer killed their enemies as Lenin and Stalin had done. Political crimes such as the invasion of Prague and the new persecution of the Jews had brought them no laurels. The Revolution was over.

But Mao and the few others present a different picture. Here is challenge, change and movement. They are felt to be alive, they have come to bring not peace but the sword, and youth all over the world calls their names, for whatever cause and to whatever purpose. They feel the fire of true paranoia. Here are those

who will defeat the fathers. Here are the immortals, the true believers. Like other mythological figures they seek to rescue the day so that the morning of happiness will never cease and the dragon of darkness be defeated. 'Darà la notte il sol lume alla terra' ('The sun shall give light to the earth by night': Monteverdi, 1614). The civilized, permissive society is expected to crumble under this onslaught as *bourgeois* parents crumble when the electric amplifiers of drugged pop groups attack their ears with orgasmic noises, so that the orgasm would never end. That is the wild apocalyptic promise and threat of it all. That was Hitler's Messianic promise and threat. He is not dead, even though he may *never* have been truly alive either, except in the regressed inner world of his followers. Incidentally, so that the archetypal hero images of this inner world could unfold in all their pompous glory, men like Hitler, Stalin and Mao were rarely seen in the everyday reality of the outer world: a Führer munching cream cakes is not inducive to apotheosis.

At this point I shall for a brief moment take you to the sobriety of my consulting room. Like most of my colleagues I have had to deal with a number of young patients who were pursued by apocalyptic fears. At times these are expressed in terms of the hydrogen bomb which would engulf them and all mankind in a catastrophe of unimaginable dimensions, while some others feel themselves assailed by less definable and therefore possibly even more disastrous forces. Thus I remember a youth beset by nameless fears who in addition had for several months suffered from insomnia as well as chronic constipation. He refused to use the couch and sat upright in a chair whence he spat vitriolic remarks at me, always in a gentle voice which I could only hear when I used my hearing aid at full strength. He assured me though that I could not possibly want to understand him anyway, hearing aid or no, as he belonged to a generation with ideals and concepts which were aimed at my destruction and all I stood for. He saw in me the personification of an evil system based on

racial inequality and class exploitation which would have to be swept off the face of the earth. In spite of his sinister utterances, however, he continued to keep his appointments, pay my bills and communicate verbally as well as by – admittedly strictly limited and restrained – gestures.

I frequently tried to draw his attention to the apparent contradictoriness between his wild feelings and their acknowledgement on the one hand, and the simultaneous docility and propriety of his behaviour. For several months I seemed to draw nothing but blanks until one day he confessed that his violence was such that it needed to be filtered through some protective inner device and remain strictly controlled lest it destroyed both me and himself. I was then in a position to interpret his insomnia and constipation as belonging to this protective device, for sleep as well as shitting were activities, or as it were 'passivities', which would do away with his control and put him in the power of autonomous forces instead. His first line of defence was to whisper contemptuously that this kind of rubbish was a waste of time, his second that he had only felt violently angry with me for going on at him, and that he had never meant to say he was a violent person in general. On the contrary, he was a peacemaker, believed in 'love not war' and had even marched to Aldermaston at great inconvenience to himself. However, as he continued with his almost – never quite – merciless poisonous attacks on me as he had done before, I was able to show him gradually that the filter which he had talked about was not only designed for protection but was also the means of effecting a tremendous concentrated attack on me, as he wanted both to spare and to destroy me.

When this patient eventually began to lose his symptoms he showed unmistakable signs of depression. He had now lost most of his ideals, he said in a clearly audible voice, and he bitterly blamed me for this. However, here was the acceptance of the reality of defeat, acceptance not denial, and thus a dialogue had

started which in spite of its pedestrian pace dynamically continued. A dialogue between father and son, between wild and autonomous fragments and the equally cut-off self, between body and psyche. This little story is, as you will observe, almost the only bit of reality I have dished up tonight.

But I have come to the end of my reflexions. Speaking in stereotypes I have projected and identified myself with archetypes both of the good and bad fathers and sons, the Germans and the Jews. It has been quite a strenuous experience at times, as I have often felt my own identity lost while writing these notes which I have just read to you. Which is this identity, mine and that of others whom I have lumped together in this or that generation, one or other nation or race? Erikson (1959) reminds us that 'theologians, philosophers, and psychologists slice men in different ways and there is no use trying to make the sections coincide', but that Luther proclaims certain total states of the whole person: 'We are totally sinners and totally just, always both damned and blessed, both alive and dead.' Such then, I feel, is the stuff of which our identity *really* consists.

My talk, somewhat idolatrous and full of quotations from supportive father-figures, was concerned with delusions as well as the disillusionment where idols and categories have lost their validity and the promise of a new beginning can arise. This will come about once the monolithic idols have been abandoned and man's real need has been established, which is concerned with his capacity to form true relationships with his human and divine being and includes the internalization of the conflict between father and son. Many talks about Hitler end with a passionate appeal that this must never happen again. To me it seems that it could well happen again whenever and *wherever* power is lying around ready to be picked up by some 'true believer', but that it *need* not, provided we allow ourselves to find our own physical and psychic paradoxical reality, as this will defeat and survive Hitler. Faust, having gone through his

demonic struggles and his encounter with woman, lives to hear the angels sing:

He who strives faithfully
Him we can save.

Luther's famous words (1566) about the theologian – that he 'is born by living, nay dying and being damned, not by thinking, reading or speculating' – express an important truth and concern us all.

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Problems in the selection of patients for psychoanalysis: comments on the application of the concepts of 'indications', 'suitability' and 'analysability'

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The problem of selecting adult patients for psychoanalytic treatment is beset with confusion. In the psychoanalytic literature, many different criteria have been put forward on which such a selection may be based, and a variety of overlapping terms has been used to describe different aspects of the selection process. As a consequence, there is often a substantial amount of uncertainty about just what is being assessed. The problem is also made difficult by the fact that methods of treatment other than psychoanalysis are often feasible and potentially helpful for certain patients who appear to be suitable for psychoanalytic treatment. Further complications arise because psychoanalysis represents both a specific treatment method and a body of thought which can be used for the understanding of psychopathology, even in those patients who are not suitable for treatment by the psychoanalytic method. Moreover, the links between psychoanalytic theory and the decision to recommend (or not to recommend) psychoanalysis are at present relatively tenuous. In addition to all these considerations it would appear that established psychiatric (and psychoanalytic) diagnostic categories provide an inadequate basis for judging whether or not psychoanalytic treatment is appropriate.

There appears to be a need for clarification of aspects of the present status of the selection process if selection procedures are to be

adequately communicated and prognostic skills sharpened. In this paper we shall be concerned only with certain formal aspects of the selection process (and some related concepts) as these apply to the situation in which a psychiatrist or psychoanalyst is confronted with the task of deciding whether psychoanalytic treatment is appropriate* or not. In fact, many factors (e.g. those pertaining to the patient's social and intellectual milieu, and which may affect the patient's own wish for psychoanalysis) operate to determine whether or not the patient enters analysis.

Psychoanalysis, a relative latecomer in the therapeutic arena (Zilboorg, 1941), had to compete with more established methods at the outset, as it must compete with relative newcomers now. Watering spas, rest cures, faradic stimulation, hypnosis, and Weir-Mitchell treatments were among the popular therapeutic modalities when Freud began to apply his techniques to those patients who failed to find lasting improvement elsewhere. Even then Freud recognized that analysis had certain disadvantages:

I consider it quite justifiable to resort to more convenient methods of healing as long as there is any prospect of achieving anything by their means [1905a].

At present, apart from modern pharmacotherapies, other methods of treatment which might be 'more convenient' might include case work by a psychiatric social worker, individual psychotherapy of one or other variety, group therapy, behaviour therapy, and family

* We are not concerned in this paper with the issue of the 'validity' of psychoanalysis as a treatment method.

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and marital therapy. The proliferation of treatment choices is a phenomenon of the past 15 or 20 years, beginning with the practice of psychotherapy (as distinct from psychoanalysis proper) by many analysts who were trained after the Second World War, in the United States as well as in England. This latter fact is of some relevance, since an analyst who practises both psychoanalysis and other forms of therapy may opt for psychotherapy with a given patient, even though the patient may have been referred originally for an analysis, or *vice versa*. He may decide this on the basis of the patient's financial status if, for example, he believes that the patient can benefit from psychotherapy as well as from analysis and the patient can only afford two sessions per week instead of five; or because he happens to have sufficient time to take a patient (who was originally referred for less intensive therapy) into psychoanalysis when the patient appears to be suitable for the latter treatment.

In the United States, where analysts are usually both medically and psychiatrically trained, there are many more self-referrals by patients as well as referrals directly to analysts from other medical specialists. In England, where a significant proportion of analysts are not psychiatrically trained, the non-medical analyst is likely to accept the recommendations of the medical colleague who refers the case. In this situation, the burden of assessment lies more heavily on the referring physician, for he cannot always rely on a wide diagnostic experience of the analyst; and even if the analyst is a medical practitioner in some cases he has not been trained as a psychiatrist. Indeed, the functions of evaluation and of analysing are quite different, as Anna Freud has pointed out (1965*a*):

...the ability to think in...genetic, dynamic, economic, structural, and adaptive terms does not in itself qualify an analyst to do diagnostic work effectively.

After a brief historical review of 'indications' for psychoanalytic treatment in the

psychoanalytic literature, the problem of appropriate terminology will be discussed. It will be seen that the notion of an 'indication' appears to be inadequate for present-day needs in this field. At the same time, the present situation, in which a number of terms such as 'indications', 'suitability', 'accessibility' and 'analysability' are used without clear differentiation, indicates a need for a clearer and more consistent approach to the problem of the selection of patients for psychoanalysis. As the question of 'therapeutic intent' in psychoanalysis (Eissler, 1965) colours the whole problem, we shall discuss it in some detail. Following this, a broad distinction will be made between *indications* for psychoanalysis on the one hand, and *suitability* for psychoanalysis on the other. The relation between selection for psychoanalysis and its place in a changing therapeutic scene, in which serious challenges arise in the area of therapy, can then be traced (cf. A. Freud, 1969).

HISTORICAL REVIEW OF 'INDICATIONS'

The early years

The symptomatic pictures to which the cathartic method seemed applicable in the early years of analysis were broadly painted. All varieties of severe and complicated neuroses were enthusiastically considered by Freud as indications for the new treatment. The list of symptoms and syndromes which qualified as indications for psychoanalytic treatment began with hysteria and hysterical symptoms, both acute and chronic (Freud, 1893), and soon included phobias and obsessional neuroses (1894). Other states were soon added, e.g. perversions (1905*b*).

Whatever Freud's early hopes were of treating psychoses, by 1913 paraphrenia or dementia praecox (schizophrenia) was excluded (Freud, 1913). However, at times he took the view that analysis might be warranted in psychoses, not for the purpose of obtaining a cure, but for purposes of research. As you know, our psychiatric therapy is not hitherto able to influence delusions. Is it possible,

perhaps, that psychoanalysis can do so, thanks to its insight into the mechanism of these symptoms? No, Gentlemen, it cannot. It is as powerless (for the time being at least) against these ailments as any other form of therapy... Will you be inclined to maintain on that account that an analysis of such cases is to be rejected because it is fruitless? I think not. We have a right, or rather a duty, to carry on our research without consideration of any immediate beneficial effect. In the end – we cannot tell where or when – every little fragment of knowledge will be transformed into power, and into therapeutic power as well [1916–17, Lecture XVII].

Listing by diagnosis

For many years the making of lists of diagnostic categories in relation to indications was attractive to writers on the subject, and to some degree it still is. In 1920 Ernest Jones listed indications by diagnosis as follows: (1) hysteria; (2) anxiety hysteria; (3) obsessional neurosis; (4) hypochondria; (5) 'fixation hysteria' (certain psychosomatic disorders such as hay fever). The 'fixation hysterias' and hypochondria had poorer prognoses. Disorders of personality now labelled by psychoanalysts as 'character disorders' were absent from Jones's list, and it was not until Wilhelm Reich published his book *Character Analysis* (1933) that this diagnostic grouping appeared on everyone's list, even though Freud had earlier (1916) referred to the role that particular character formations could play in the development of resistances to analytic treatment.

In 1945 Fenichel took a step towards the recognition that diagnosis was an insufficient guide to patient selection, when he listed diagnoses according to decreasing 'accessibility' to psychoanalysis: (1) hysteria; (2) compulsions and 'pregenital conversions' (such as stuttering and psychogenic tics); (3) neurotic depressions; (4) character disturbances; (5) perversions, addictions and 'impulse neuroses'; (6) psychoses, including manic-depressive psychosis and schizophrenia. Fenichel believed that the psychoses were suitable for analysis to the extent that the remainders of

previous object-relationships and the longings to regain such contacts made the development of a transference a possibility. For Fenichel, the qualities of the person behind the illness became a major consideration.

Edward Glover (1954, 1955) attempted to reach a compromise between the listing of diagnostic indications and a recognition that the symptoms, which lead to the diagnosis, are intimately linked with the person in whom they develop, with his personality and life style, and with the developmental stage of early life in which his illness can be regarded as primarily rooted. He arranged diagnoses in groups labelled 'accessible', 'moderately accessible' and 'intractable'. In the 'accessible' group he included the conversion and anxiety hysterias, cases of mixed hysteria and obsessional neurosis, reactive depressions, and certain kinds of sexual disorder such as 'facultative' bisexuality, simple impotence, ejaculatio praecox, and early marital problems. The 'moderately accessible' group included obsessional neurosis, and some perversions such as fetishism and transvestitism. Certain problems of alcoholism and drug addiction were part of this group.

The 'intractable' group was exemplified by various kinds and phases of the psychoses, severe psychopathy, and 'psychotic' characters. Glover recognized that placing a patient in a particular group was to a certain extent an arbitrary decision, since such factors as secondary gain, or the suspicion of a latent psychosis, could drastically alter the analyst's estimate of the patient's suitability for analysis. The emphasis in Glover's approach was a shift away from indications for analysis, narrowly based on symptoms, towards an assessment of suitability for analysis based on a broader evaluation of the patient's personality, his history and his present functioning.

The widening scope

Various authors have, from time to time, warned that diagnostic categories and specific symptoms are unreliable indices to the suitability for analysis of any individual patient.

For example, Kubie (1948) pointed out that 'any and every neurotic symptom can occur in any of a multitude of varied psychopathological soils'. Anna Freud (1954*a*) commented further on the limitations in the psychoanalyst's ability to assess the meaning of symptoms:

At the beginning of analysis, before we have insight into the structure of a neurosis, it is impossible to predict how the patient will respond to treatment. There is no guarantee that two individuals with the same symptomatology will react similarly, to the same technical procedure.

In a symposium on 'The Widening Scope of Psychoanalysis' (A. Freud, 1954*b*; Stone, 1954; Jacobson, 1954) the major issue was the broader criteria of suitability now necessary rather than the wider diagnostic range of indications for analysis. This symposium marked a turning-point in the psychoanalytic literature in its substantial change of emphasis from diagnostic criteria to criteria of 'suitability' (A. Freud, 1954*b*; Stone, 1954).

In a follow-up study of patients selected for analysis Knapp *et al.* (1960) demonstrated that the diagnosis of hysteria did not necessarily mean that the patient could be successfully analysed (much as Glover had suggested in 1954). The problem was deftly dissected by Zetzel (1968) when she was able to show how the assessor could distinguish between four subgroups of women who could all be given the diagnosis of hysteria. The subgroups of patients had widely different capacities to benefit from psychoanalysis. However, in spite of the shift away from attributing special significance to individual symptoms, there are still occasional references in the literature to their significance. Thus, for example, Karush (1960) maintained that a phobia of dirt forecasts a poorer outcome than a 'fear of motion' but, in the panel discussion concerned, this statement stimulated prompt objections.

In the past 25 years more attention has been paid to the psychosomatic disorders, including peptic ulcer, ulcerative colitis, bronchial asthma and dermatitis. It would appear that the diagnostic range has been widened more or

less as far as it can go. In fact, Kuiper has recently made a plea for 'narrowing the scope of psychoanalysis' (1968). In his development of this idea, symptoms and diagnoses take second place to a consideration of the necessity for a healthy part of the ego to be present for the analytic procedure. In fact, as long as 15 years before Kuiper, Stone (1954) had noted the tendency on the part of analysts (and patients as well) to an over-expansion of indications based on a somewhat magical expectation of help from psychoanalysis. He ventured the somewhat heretical idea that few people are without troubles, and that these must often be met 'if at all, by "old-fashioned" methods: courage, or wisdom, or struggle, for instance...'.

PROBLEMS OF TERMINOLOGY

Indications and contra-indications

Freud adhered to the classical medical model of assessment, which makes use of the concept of the 'indication'. This can be regarded as a suggestion or direction to the treatment of a disorder, derived from the symptoms or from the facts of the patient's history. A contra-indication is similarly derived, and suggests that a particular treatment *not* be employed. The terminological distinction between a symptom (as something of which the patient complains) and a sign (as something elicited from the patient by examination) is not always maintained in psychiatry and hardly ever in psychoanalysis. The terms tend to be used interchangeably, although in fact the difference between what the patient complains of and what is observed by the analyst is regarded as being of crucial importance.

One of the defects of the literature on the selection of patients for psychoanalysis is a confusion between indications (and contra-indications) on the one hand, and criteria of suitability (and unsuitability) on the other. While indications may be taken to refer to overt and distinct symptoms or signs, or constellations of these, the criteria of suit-

ability involve the assessment of qualities and capacities in the patient. In our view a sharp differentiation between indications and criteria of suitability is necessary and even crucial for a clarification of the problem and of the various points of view stated in the literature. To illustrate this, we might say, for example, that an obsessional neurosis might constitute an indication for psychoanalysis, but the presence or absence of certain qualities in the patient might render him unsuitable for the treatment or the treatment unsuitable for him.

The distinction between indications (in the sense in which we are using the term) and criteria of suitability was implicit in Freud's attitude towards the treatment of perversions (1905*b*).

The fact of a person struggling this way against a compulsion towards inversion may perhaps determine the possibility of his being influenced by suggestion or psychoanalysis.

We could say that here Freud accepted the patient's symptoms as an indication for treatment, but the criterion of suitability is based upon an assessment of whether or not the patient struggles against the compulsion (i.e. whether or not it is 'ego-alien').

Most psychoanalysts regard the presence of a psychotic illness as a contra-indication to psychoanalysis. However, in this connexion contra-indications based on the patient's symptoms and criteria of unsuitability for psychoanalysis overlap. The mental state of the psychotic patient is usually such that he lacks the necessary requirements for sustaining a treatment alliance (Sandler *et al.*, 1970*a*). This is regarded as necessary in order to enable the patient to cooperate in treatment, to deal with transference phenomena as they emerge and to gain and retain insight. However, not all authors agree that an active psychosis is a contra-indication for psychoanalysis, nor that the presence of a psychotic illness implies that the patient is unsuitable for psychoanalytic treatment. There is a large and controversial literature on the subject of treating psychotics by the standard psycho-

analytic technique or some modification of it (Sullivan, 1931; Federn, 1943; Rosen, 1946; Searles, 1961, 1963, 1965; Rosenfeld, 1952, 1965, 1969). It would appear that some of the problems in this area could be clarified if the distinction between indications and criteria of suitability was maintained. From this point of view, the question would not be whether psychotics are treatable by psychoanalysis or not, but whether any particular psychotic patient shows the presence or absence of those qualities which would make it more likely that analysis could be of help.

Mental deficiency is generally regarded as a contra-indication for psychoanalysis, but this is somewhat misleading, because what is usually meant is that a patient with symptoms calling for treatment who is, at the same time, mentally deficient, is unsuitable for treatment because of his low intelligence. He might have a disturbance which, on its own, might be regarded as an indication for the treatment, but the person in whom the disturbance exists is unsuitable for treatment.

Suitability

From what has been said previously, it would follow that the selection of a patient for treatment depends far more on the assessment of criteria of suitability than on the symptomatic picture which he presents. We have pointed out that indications for psychoanalytic treatment might be present, but the patient is unsuitable for analysis. Similarly, a patient might present with a symptom which is known not to respond well to psychoanalysis (e.g. stammering or a tic), but is assessed, on the basis of other criteria, as being a suitable person to undergo psychoanalysis and who would benefit from it, although his original symptoms might remain. Perhaps we should rather speak of the suitability of the treatment for the person, in his particular life situation, rather than, as is the custom, to assess the suitability of the person for the treatment. Otherwise the fitting of some patients to the Procrustean couch of psychoanalysis might be more in the short-term

interest of the analyst than in the long-term interest of the patient.

Freud's concern about the selection of patients for psychoanalysis was expressed as early as 1895. He used the term 'suitable' when referring to certain aspects of his analytic patients which involved him in a way different from his previous tabetic or rheumatic patients, a difference which took into account features of their lives not directly related to symptoms and indications *per se*.

I cannot imagine bringing myself to delve into the psychical mechanism of a hysteria in anyone who struck me as low-minded and repellent, and who, on closer acquaintance, would not be capable of arousing human sympathy (1895).

Freud further required that his patients should be possessed of a certain level of intelligence and strength of mind, that they give complete consent and attention, and 'above all their confidence'. But the early criteria of suitability were dependent not only on Freud's feelings of morality, but also on his technique at that time, as it was evolving away from the use of hypnosis. Thus a 'positive transference' was a prerequisite at the outset, or at least sufficient 'positive transference' to maintain the treatment.

A good number of the patients who would be suitable for this form of treatment abandon the doctor as soon as the suspicion begins to dawn on them of the direction in which the investigation is leading [1895].

By 1904 Freud had made a clear distinction between the indications for analysis as they are still presently employed with respect to diagnosis, and the applicability of the treatment or what we have referred to as suitability for treatment. After listing as indications all the clinical pictures that may be presented in hysteria, and all forms of obsessional neurosis, he went on to say:

This does not imply, however, that it can have an unlimited application. The nature of the psychoanalytic method involves indications and contra-indications with respect to the person to be

treated, as well as with respect to the clinical picture [1904].

In addition to the stipulation that he had made in 1895, i.e. that the patient give complete attention, he now required that the patient 'be capable of a psychically normal condition'. By this he meant to exclude patients with psychoses, under the influence of drugs, or those with confusional states (1905a). These conditions could be said to make the patient unsuitable for the treatment. In the same paper, he remarked that 'Psychoanalysis should not be attempted when the speedy removal of dangerous symptoms is required.' At this time patients with constitutional deficiencies ('traits of an actually degenerate constitution') were considered unsuitable for analysis. These deficiencies included deep-rooted personality malformations, epilepsy, criminality, alcoholism and congenital syphilis.

Accessibility

Further terms used by Freud were 'accessible' and 'inaccessible'. These referred to whether or not analysis could reach and influence the patient. These terms rapidly gained wide usage, and the notion of 'accessibility', as a quality of the patient, is in current use. Thus an obsessional patient might be possessed of the indications for psychoanalysis by virtue of his symptoms, and of all the criteria of suitability except 'accessibility'; if he is unable to think in 'psychological' terms, to see connexions between events and feelings in himself. This incapacity has been referred to as a 'lack of psychological grasp' (Joseph, 1967). And it seems obvious that a patient might be judged 'inaccessible' because of other qualities, e.g. complete withdrawal from the outside world or preoccupation with hypochondriacal concerns, lack of motivation for treatment, etc.

In 1916 Freud used the term 'accessibility' in reference to the difficulties encountered in the treatment of psychotics.

In those days we did not know *a priori* that paranoia and dementia praecox in strongly

marked forms are inaccessible, and we had a right to make a trial of the method in all kinds of disorders [1916-17, Lecture XXVIII].

A patient treated by Freud was treated a second time by Ruth Mack Brunswick, who refers to the same phenomenon, commenting that 'the insight won during the first analysis was responsible for the patient's final accessibility' (1928).

Nunberg regarded accessibility as being dependent on the patient's psychic discomfort (1942):

In order to render a patient accessible to analytic treatment, one must at least make him aware of having a conflict; moreover he must *suffer*.

However, not all those who have a conflict and who also suffer are necessarily accessible to analysis. Conversely, being unaware of possessing conflicts, or not suffering from symptoms, would not, to many analysts, indicate 'inaccessibility'.

Fenichel (1945) referred to the general accessibility of the patient without specifying the nature of 'accessibility'. In 1954 Glover took the term 'accessible' to apply particularly to what he regarded as the crucial ability of the patient to form a workable transference relationship. In the sense that the patient is able to be reached or influenced by analysis, performed by a particular analyst, accessibility appears to be related to the factors which go into the making of a treatment alliance (Sandler *et al.*, 1970a).

If accessibility is to be regarded as a dimension relevant to the decision to recommend psychoanalytic treatment it should be clearly placed alongside other criteria of suitability. It is by no means an alternative to the concept of suitability, even though it has occasionally been used as such. Moreover, its use does not appear to offer advantages over the detailed consideration of the various components necessary for an adequate treatment alliance, i.e. the capacity to tolerate a certain amount of frustration, the capacity to regard oneself as one might regard another, the existence of

a degree of 'basic trust', identification with the aims of treatment, etc. (Sandler *et al.*, 1970a).

Analysability

'Analysability' is currently a popular term in discussions of the criteria for selecting patients for psychoanalysis.* Among its early users was Sachs (1947), but the reasons for its current popularity are obscure, as it can mean little else than a measure of the extent to which the patient is judged to be suitable for analysis. The current confused state of the terminology is well reflected in a recent monograph entitled *Indications for Psychoanalysis* (Joseph, 1967). In it the symptoms of the patient are not the main focus of interest, but emphasis is given instead to those features which we have considered under the heading of 'suitability'. The phrase 'indications for analysability' is employed to mean the criteria of suitability for analysis, but instead of clarifying matters the situation is rendered obscure by the consequent amalgamation of indications for psychoanalysis and criteria of suitability.

One of the main disadvantages of the term, and possibly one of the reasons for its use, is that it obscures the distinction between that which is 'analysable' in the sense of 'that which can be understood', and the changes which analysis may bring about in the patient. While the material of the most grossly disturbed and unsuitable patient may be analysable in the sense that the analyst may be able to discern its unconscious meaning, the patient himself may not participate in this understanding nor in the analytic process, apart from being present and producing 'analytic material'. The idea that any patient can be 'analysed' in the sense that his material can be understood and interpreted is based upon magical expectations of the potency of analysis as a therapeutic technique, and the use of the term gives support to those analysts who believe that they, by giving the correct

* Occasionally the term 'treatability' is used as a synonym for analysability in the psychoanalytic literature.

interpretations, will always be able to change the patient; or that more analysis is the answer to an unsatisfactory therapeutic result. This must inevitably affect the selection process. It is possible that part of the attraction of the term lies precisely in the fact that it obscures the vital distinction between whether the analyst understands the patient and whether the patient can benefit from the analytic procedure, at any given time.

THERAPEUTIC INTENT

Although we have referred so far to psychoanalysis as a treatment method, the psychoanalyst is in the paradoxical position of seeing cure as a desirable by-product of the process of analysis, but a by-product nevertheless. His function is to analyse the material brought by his patient, to follow it wherever it leads, and to communicate to the patient, by appropriate interventions, his understanding of the patient's productions. In this he is guided by his knowledge of the capacities and state of the patient, and will frame his communications accordingly (Sandler *et al.*, 1971). However, he is also obliged to take the patient's suitability for analysis into account, and to assess the benefits to the patient of psychoanalytic treatment in relation to other available modes of treatment. Few analysts would still maintain that the decision to take a patient on for analysis is unrelated to the aim of curing the patient's symptoms or of making beneficial changes in his personality structure. Other factors being equal, the analyst's ideas about what analysis can offer the patient and his own ideals concerning the desired consequences of analysis must influence his decision on whether to recommend or accept a patient for analysis or not.

From the beginning, a research or investigative attitude was characteristic of Freud's approach to the problem of gaining an understanding of psychological illness, although he never lost sight of the fact that therapy was the *raison d'être* of these researches (1893, 1913, 1937). However, he expressed the view

that, in the case of a patient for whom no hope of improvement could be entertained, the lack of therapeutic result was of little importance compared with the knowledge gained by means of analysis (1916-17, Lecture XVI).

In 1893 Freud emphasized the fortunate coincidence that the method of treatment and the method of investigation seemed to be identical and to be equally productive. By 1904 Freud was convinced that analytic treatment did not have an unlimited application, and in 1905 maintained that the prospect of attaining symptomatic relief was paramount (1905*a*).

In two papers published in 1909, Freud again emphasized the therapeutic aspects of psychoanalysis (1909*a, b*), and saw the scientific results of its application as by-products of the therapeutic aims. Indeed, perhaps more was to be learned from cases of therapeutic failure than from those in which treatment had been successful.

The particular relationship of therapeutic aim to analytic technique was adumbrated by Freud in 1909.

Therapeutic success, however, is not our primary aim; we endeavour rather to enable the patient to obtain a conscious grasp of his unconscious wishes [1909*a*].

Therapeutic success would then follow of its own accord. He was rather more explicit about the analyst's role in 1927:

I scarcely think, however, that my lack of a genuine medical temperament has done much damage to my patients. For it is not greatly to the advantage of patients if their doctor's therapeutic interest has too marked an emotional emphasis. They are best helped if he carries out his task coolly and keeping as closely as possible to the rules.

Freud recognized the possibly antithetical properties of the therapeutic and research orientations in 1912.

One of the claims of psychoanalysis to distinction is, no doubt, that in its execution research and treatment coincide; nevertheless after a certain point the one opposes the other.

that required for the other. It is not a good thing to work on a case scientifically while treatment is still proceeding. . . Cases which are devoted from the first to scientific purposes and are treated accordingly suffer in their outcome; while the most successful cases are those in which one proceeds, as it were, without any purpose in view. . . The correct behaviour for an analyst lies in swinging over according to need from the one mental attitude to the other, in avoiding speculation or brooding over cases while they are in analysis, and in submitting the material obtained to a synthetic process of thought only after the analysis is concluded.

The implication here is that if the psychoanalyst pays particular attention to some aspect of the patient's material which holds a special research attraction for him, he may interfere with the progress and development of the analysis as a whole. In addition, it seems probable that if an analyst with particular research interests is involved in selection, these interests may affect his assessment of the suitability of the case for psychoanalysis.

When the analyst's intention to be of help is magnified into the ambition to cure, difficulties begin. As Freud put it (1912):

Under present day conditions the feeling that is most dangerous to a psychoanalyst is the therapeutic ambition to achieve by this novel and much disputed method something that will produce a convincing effect upon other people. This will not only put him into a state of mind which is unfavourable for his work, but will make him helpless against certain resistances of the patient, whose recovery, as we know, primarily depends on the interplay of forces in him.

Eissler has, more recently, elaborated on this (1965):

...one can observe in clinical reality that it is the very therapeutic intent, curiously enough, that often becomes the barrier to the patient's recovery. In the psychological intimacy that surrounds observer and the subject in the psychoanalytic situation, the observer's motives have an effect upon the subject even when they are not verbalized.

Or, as Greenson (1967) has put it: 'The wish to cure should not be confused with patho-

logical therapeutic zeal.' Leo Stone (1961) had stressed that the basic attitude of the analyst should be one of interest in the patient and a wish that the patient should get well. This wish, if not disproportionate, 'enables the analyst to develop those subtle and complex skills in communicating necessary for psychoanalytic work' (Greenson, 1967).

Greenacre (1966) has pointed out that analysts with too much therapeutic zeal (based on some pathological need for success) will overvalue the power of analysis, and consequently recommend it injudiciously, other methods of treatment being undervalued.

Other forms of ambition may equally affect the form of treatment recommended. Parin (1958) has mentioned the analyst's need for money as a factor which can influence his thinking, and Glover has pointed out that

Indeed, one cannot too earnestly recommend the commencing analyst who can afford to do so to select his cases in accordance with their analytical tractability rather than with their financial solvency [1955].

Referrals to recently qualified analysts of difficult or unsuitable cases by their senior colleagues may also complicate the beginner's selection problem, especially if he fears he may alienate colleagues who are professionally important to him.

Unwarranted therapeutic pessimism gives rise to equal problems. Gitelson (Kramer, 1967) remarks: 'If you assume the patient is unanalysable, you won't be able to analyse him.' Nunberg (1969) has commented that there are instances when a patient is accepted, in spite of the fact that he appeared, on initial impression, to be too disturbed for analysis to succeed, and it is found that the analyst obtains 'access to the healthy part of the ego, which often paves the way for a regular and successful analysis'. A period of extended evaluation, or even of preparatory work, may lead to analysis, or may never go beyond some form of supportive psychotherapy. Aarons (1962) suggests that there is a place for a judicious therapeutic optimism, and the

opportunity to succeed should not be missed when there is reasonable doubt at the time of assessment.

CRITERIA OF SUITABILITY

In this section we shall consider a number of criteria of suitability for psychoanalytic treatment. In a sense they represent the simplest and most basic criteria. As they are often taken for granted, we believe that they are worth re-examining.

The upper age limit

Freud suggested an upper age limit of about 50 (1904) because in older patients the mass of material was regarded as unmanageable, the time required for treatment was too long, and 'the ability to undo the psychological processes begins to grow weaker'. He also remarked that 'Old people are no longer educable' (1905a) (Freud was 49 at the time).

Most subsequent contributors to this topic have increased the age limit. Abraham (1919) pointed out that the age of the neurosis was more important than the age of the patient. Ernest Jones (1920) reported good results up to the age of 60, but suggested that increasing age lessened the opportunity for readjustment, thus affecting the analyst's interest in the case. More recent opinion has varied. Knight (1954) suggests an upper age limit of 50, with certain exceptions to be made. He provided no rationale for this.

Glover (1954) considered that with increasing age the factor 'secondary gain' (see Sandler *et al.*, 1970b) became of greater importance, and the analysis of the transference more difficult. However, Leon Saul (1958) believes that analysis can be a 'thoroughgoing help' in the 60s.

In the study by Knapp *et al.* (1960) referred to previously, it was found that, in a population of 100 patients aged 27-41, the older the patient, the more suitable he was thought to be. This suggests that the relation between age and suitability, in the total population, is far from being a linear one, and it is possible that the most suitable and sufficiently motivated

patients are those who experience difficulties once their lives have become relatively stabilized.

Freud suggested that there was a difference between the sexes with regard to the changes which occur with age (1933).

A man of about 30 strikes us a youthful, somewhat unformed individual, whom we expect to make powerful use of the possibilities for development opened up to him by analysis. A woman of the same age, however, often frightens us by her psychological rigidity and unchangeability. Her libido has taken up final positions and seems incapable of exchanging them for others. There are no paths open to further development; it is as though the whole process had already run its course and remains thenceforward insusceptible to influence - as though, indeed, a difficult development to the femininity had exhausted the possibilities of the person concerned. As therapists we lament this state of things, even if we succeed in putting an end to our patient's ailment by doing away with her neurotic conflict.

However, Freud's view of women in this context has not been echoed in the subsequent psychoanalytic literature.

It would appear that the setting of an upper age limit as a criterion of suitability for analysis may be relatively arbitrary, although we can expect that, in the later decades of life, fewer patients will be regarded as suitable. Clearly such an assessment must take into account the changes due to age in the individual patient rather than the simple factor of age itself. Child analysis has shown (A. Freud, 1965b) that children who were in the past not thought suitable for analysis may be successfully analysed if appropriate modifications of analytic technique are made. It seems reasonable to consider that modifications of technique, designed to meet the needs and limitations of the older patient, may equally be legitimate and desirable.

Intelligence

The criterion that the patient should be intelligent (Freud, 1895) was qualified by Freud to the possession of 'natural intelligence'.

(1904). This was an effort to avoid the issue of educational level, although Freud did require 'a reasonable degree of education' (1905*a*). In 1920 Jones referred to his own experience in treating a number of patients from the 'uneducated classes' successfully.

In 1945 Fenichel considered feeble-mindedness to operate against the choice of analysis as a treatment method, but he cautioned that 'pseudo-debility' (pseudo-feeble-mindedness) may be a symptom of a psychological disorder, a point which had been made and discussed by other authors (Jones, 1910; Bornstein, 1930; Mahler-Schoenberger, 1942; Hellman, 1954). The problem facing the assessor is that of differentiating between true and apparent stupidity.

Perhaps the highest level of intelligence was required by Knight (1954), who demanded that the patient be of at least bright normal intelligence.

It is our impression that the required level of intelligence may have been placed too high by many psychoanalysts because of their own preference for working with intelligent patients. Again, the question arises, as with age, of what the lower intelligence represents, in any particular patient, in terms of his capacity to benefit from analytic treatment. The crucial question would appear to be whether the patient's intelligence level is too low for that patient to form an adequate treatment alliance and, in particular, whether he is thought to have the capacity to develop a sufficient degree of insight.*

* It is an interesting fact that analysts commonly appear to overestimate the intelligence of their patients. In case reports the patient is usually described as 'very intelligent'. What may be regarded as intelligence may reflect very specific qualities of the patient's capacities, e.g. his ability to establish a 'verbal rapport' with the analyst. This may lead to an overestimation of a patient's intelligence. Special cognitive deficiencies (e.g. a low capacity for abstract thinking relative to the patient's 'verbal' intelligence) may go unnoticed, particularly at the assessment stage (cf. Herskovitz, 1970).

Ethical and moral considerations

Freud's requirement that the patient be possessed of a certain level of 'ethical development' was clearly based on feelings and attitudes aroused in the analyst, not on judgements of the value of the patient to society.

If the physician has to deal with a worthless character, he soon loses the interest which makes it possible for him to enter profoundly into the patient's mental life [1904].

Jones (1920) agreed, but pointed out that much better results can be achieved in 'worthwhile' characters. An attempt to maintain the same view without resort to moral judgement can be found in a paper by Bibring (1937), who referred to the differences between those patients who value their relations to others and those who value people less, and who also show a tendency to more direct gratification of their instinctual impulses.

In discussing the factors which may militate against the recommendation for analysis with a particular analyst, Fenichel (1945) referred to the fact that a particular analyst may have limitations with regard to a patient with certain kinds of problems. This view suggests that a patient who is regarded as having a certain type of 'moral deficiency' may be unacceptable to one analyst while capable of being successfully analysed by another.

After 1945 the general analytic view seemed to veer more towards regarding the patient who shows 'moral' disturbances as having a personality problem. The question of the 'worth' of the patient has come more to the fore in the context of the possible contribution the patient might make to society, given a successful outcome of the analysis. According to Saul (1958) it would follow that an analyst is irresponsible if he did not choose his patients with this potentiality in mind. It is obvious that the adoption of such a view must raise considerable problems for the analyst. We are reminded of Freud's long-held conviction that surrealist painters were 'complete fools' (Jones, 1957).

Sterba (1969) has put forward a view opposite to that of Saul.

Nowadays we analysts cannot let such value judgments enter into our selection of patients... [we must] learn to set aside moral appraisal of patients as unscientific and incompatible with a neutral, objective position we are supposed to take in the therapeutic situation.

It is quite understandable that many analysts may be reluctant to take a patient on if his character is such that he offends some important aspect of his own feelings, even though he may have insight into his own attitudes towards the patient. In such a case, it might be better to refer the patient elsewhere rather than to set aside his own feelings, as Sterba suggests. This is relevant to the process of evaluating the suitability of the patient for analysis. He may, as Fenichel has commented, be suitable for analysis by one analyst and not by another. Nevertheless, most analysts would agree with Ella Sharpe (1950), who commented: 'The person on the couch has his own problems, and it is not for us to envisage any result out of the analysis in accordance with our particular sense of values and desirabilities.'

Suffering and secondary gain

The requirement that the patient be motivated by the fact that he suffers from his symptoms was clearly stated by Freud (1905a) as a condition of suitability for psychoanalysis. When he identified 'secondary gain' as a source of resistance (1926), it followed that the manifest suffering of which the patient complained had to be set off, by the assessor, against the secondary gains accrued during the course of the illness. However, the patient is likely to be less open about these gains, or less aware of them, or both. The evaluation of the significance of the patient's suffering is still more complicated when the tendency to masochism has to be taken into account (Freud, 1937), for there may be an unconscious gratification in the patient from his symptoms, making the maintenance of suffering important for his psychic equilibrium. The patient's request for self-understanding may be founded

on a wish for additional self-punishment and self-condemnation, and a judgement has to be made whether the patient can overcome his masochistic tendencies during the analysis.

When Freud introduced the concept of 'secondary gain' as a source of resistance in 1926 he said:

The ego now proceeds to behave as though it recognized that the symptom had come to stay and that the only thing to do was to accept the situation in good part and draw as much advantage from it as possible.

The concept of secondary gain can be extended from symptoms to character traits as well, over and above the initial gains which the trait or symptom provided. The fact that a symptom may be a source of suffering is no guarantee that it is free from secondary gains. In some disorders the only source of gratification which the patient may experience is that associated with the secondary gain which has accrued to the symptom (Fenichel, 1945).

Analysis itself may provide a potential source of secondary gain for certain patients, particularly when it may be used as a source of masochistic gratification. Other very dependent patients may exploit the analytic situation in such a way that their need for the well-being consequent on a dependent relationship is fulfilled.

The evaluation of the patient's secondary gains from his illness or his personality traits is an important area of assessment in regard to recommendation for analysis. However much the patient may desire help, he may have so much to lose in the shape of his secondary gains that analysis would not prove to be a viable proposition for him. Thus the assessor must explore, for example, the extent to which the neurosis may hold together an otherwise shaky marriage, or enable the patient to hold some power over others because of the effect on them of his problems.

Confidence in the analyst and the treatment alliance

The development of the treatment alliance concept (cf. Sandler *et al.*, 1970a) has helped

to highlight certain attributes and capacities of the patient which had not been grouped together in this way before. The essential motivation of the patient enters into this, and qualities such as an ability to establish rapport were recognized early by Freud (1913) as essential for treatment. The capacity for reality-testing has been emphasized from this point of view in recent years (Greenson, 1965, 1967) as well as the quality of 'basic trust' (Erikson, 1950). The potential for developing a treatment alliance should be distinguished from the wish to recover (Sandler *et al.*, 1970a), and the assessment of the patient's potential for forming a treatment alliance is a part of the current thinking of many analysts. The ability to recognize and to tolerate affect, to observe one's self as if one were another and to be sufficiently motivated towards and capable of accepting the need for help with internal problems are all components of the patient's contribution to the treatment alliance. In a broader sense, the treatment alliance may depend, to a variable degree, on the attitude of his family and friends towards analysis. Accepting the need for help, for example, may be excessively frightening to a patient with unresolved conscious or unconscious homosexual conflicts because of his very great anxiety about being relatively passive in the analytic situation, and this may be too great for him to tolerate the analytic process.

To a large extent the elements which comprise the treatment alliance involve functions of the personality which normally develop outside the sphere of neurotic conflict (Hartmann, 1939). To the extent that they are impaired by early deprivation or later conflict, the ability to develop a treatment alliance will be similarly affected. Zetzel (1965) has added to the necessary elements for a treatment alliance. She includes the following: evidence of 'good' early identifications, of consistent object relations, of successful sublimations, and of the ability to withstand anxiety and depression.

The early requirement of complete confi-

dence in the analyst probably ceased with Freud's recognition (1905c) that the analysis of the hostile transference was required for a successful treatment, and he did not mention the requirement of complete confidence again. In 1913, for example, it was clear to him that the wish to keep secrets from the analyst boded ill for treatment, as it was a resistance which, if acceded to by the analyst, would make analysis impossible. In the same paper, he pointed out that confidence at the outset was insufficient, and that an 'effective transference' must come about before the full work of analysis could begin. What appears as a complete confidence may itself be a resistance and be the only sign of fantastic expectations from the analysis. Nunberg stressed this point in 1926, and gave as an example the frequent desire of impotent men that treatment provide them with hyperpotency. The woman's wish that analysis would provide her with a penis is perhaps more widely recognized (Freud, 1933).

Nowadays it would appear that the analyst is not surprised to find that the patient has misgivings about the analysis, either at the stage of assessment or in the early analytic sessions. It is less usual that early misgivings are expressed about the person of the analyst himself, although an early transference reaction of this sort may provide a valuable clue to the patient's pathology. In some patients very early experiences of deprivation may result in a disturbance in their capacity for 'basic trust', manifested in their continuing lack of confidence in the analyst. Clearly, confidence is a complex phenomenon which influences both analyst and prospective patient in their initial assessments of each other.

In 'Analysis Terminable and Interminable' (1937) Freud considered the personality of the analyst as a factor which could unfavourably influence the efficacy of an analysis. Although Freud was referring to psychical abnormalities of the therapist which could limit his ability to work beyond a certain point, a patient may pay great attention to a physical or a mental characteristic of the analyst in such a way as

to prejudice the initial assessment as well as subsequent analysis.

The patient's first contact with the analyst may offend or frighten him because of some personal feature of the analyst. As a consequence the patient may declare analysis to be an unsuitable treatment for him, or request another analyst. Some prospective patients have strong views about which sex they prefer their analyst to have, or which religious or ethnic background, or may object to even more intimate attributes of the analyst's person.

Pollock (1960) has drawn attention to the fact that the patient's 'specifications' for a therapist may have some validity. The view that such initial reactions are evidence of resistance and defensiveness leads to a disregard of this possibility (Thompson, 1938). While such reactions can be dealt with in the analysis, and often do crop up in the course of an analysis, unless they are respected at the outset, they may lead to an unsuitable match between analyst and patient. A patient may be wrongly labelled as unsuitable because of his failure to develop a treatment alliance with that analyst, and the analysis may fail.

Greenson has recognized that the so-called 'real' relationship between analyst and prospective patient may contain elements which, if analysis is attempted, will make analysis unlikely (1967). He gives extremes of political view in prospective patients as an example. Anna Freud has called attention to this aspect of the relationship as it bears on the course of therapy, but it is equally applicable to the course of the selection process (1954b):

With due respect for the necessary strictest handling and interpretation of the transference, I still feel that somewhere we should leave room for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. I wonder whether our – at times complete – neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe only to 'true transference'.

TRIAL ANALYSIS

One method of postponing the decision regarding the suitability of a patient for analysis is the recommendation that the patient have a 'trial' period of analysis, after which the analyst may find himself in a better position to determine whether analysis would seem likely to succeed. The practice of conducting a period of 'trial analysis' is not as widespread nowadays as formerly, and a short comment on it would seem appropriate, as current opinion differs as to its value.

In 1913 Freud advocated that the patient should, as a matter of routine, be taken into analysis provisionally for a period of one or two weeks. (Analyses at that time were substantially shorter in duration than at present.) Freud was concerned, among other things, with the danger that apparently neurotic symptoms might, under some circumstances, herald the onset of an overt psychosis. Later, Fenichel (1945) divided treatment into a 'trial analysis' of several weeks and a 'final analysis' of unspecified length. He believed that one could not decide that the patient needed a 'complete analysis' until such a trial had been made. Only then, in Fenichel's view, could the analyst adequately evaluate the factors which operate to make for a viable analytic process.

In Glover's well-known 1938 questionnaire to members of the British Psycho-Analytical Society (Glover, 1955), analysts were asked whether they frequently recommended a 'trial trip' of analysis, and two-thirds of those responding indicated that they did not. The idea appears to have met with some disapproval in recent years. For example, Gitelson has remarked: 'To tell the patient it is a trial analysis creates an artifact which conditions the analysis thereafter' (in Kramer, 1967). On the other hand, Loewenstein (1964) has maintained that it is impossible to assess the suitability of the patient for analysis in advance. Similarly, Greenson is of the opinion that a trial at analysis is the only way in which a successfully camouflaged defect in the capa-

city for establishing object relationships, and thus a treatment alliance, can be revealed. He suggested that most analysts who make use of a trial period of analysis do not, in fact, bring about the complications which Gitelson described consequent on confronting the patient with being 'on trial'. Instead, he points out, many analysts usually imply a provisional element in various ways at the beginning of treatment, and if the patient turns out to be suitable for analysis, take the patient's concern about being on trial as part of the analytic material and analyse it accordingly. Greenson suggests that the change in tactics on the part of the analyst which this implies accounts for Glover's earlier finding (Greenson, 1967).

Greenson has also made a number of observations regarding the length of time involved in the introductory period. Instead of the period of weeks mentioned by Freud and Fenichel, it would appear to range in duration, with his own patients, from months to years, although there are some patients about whose suitability or unsuitability one can be certain within a shorter period.

The major value of some form of trial period of analysis would appear to lie in the opportunity it provides for the analyst to evaluate the capacity of the patient to develop a sufficient treatment alliance. Gitelson (1952) adds that the trial analysis is also a test of the analyst's capacity to enter into an analytic relationship with the patient. One of the possible disadvantages of a routine trial period may be that its use may encourage the analyst to take patients who are intrinsically unsuitable into analysis. The analysis is continued thereafter because a careful assessment of the criteria of suitability has in some way been by-passed by the analyst once the analysis has begun and the patient is willing or even eager to continue treatment. A further disadvantage of a routine trial period, in certain patients with the tendency to 'split off' part of their lives from analytic investigation, is that the trial period agreement may enable crucial material to be (consciously or unconsciously)

withheld until later. The analyst may therefore make the decision to embark on analysis after the trial period, only to find later that he has made an incorrect decision.

DISCUSSION

It should be emphasized that the criteria of suitability for psychoanalysis described in the literature in a sense represent ideal conditions. The patient must have a sufficient degree of intelligence, an ability to tolerate painful affects and be capable of sublimation. His object relationships will be relatively mature and his capacity for reality-testing will be more-or-less well established. His life will not be centred around his analysis so that he becomes unduly dependent on it, and his moral character and educational achievements will have assured him of a good position in life with adequate rewards. It would seem that we may be in the paradoxical position of finding that the patient who is ideally suited for analysis is in no need of it!

In practice, patients present with greater or lesser disturbances of psychological structure and function, in one or more areas of their personality. As Waldhorn has pointed out, few patients fulfil the ideal criteria of suitability (1960) and yet a number may be analysed successfully, although 'Where many of these [unsuitable] features are present, or several to an intense degree, analysis is proportionately more difficult, sometimes impossible.'

As a shift of emphasis occurs, away from indications (based on the medical model of symptom evaluation) towards criteria of suitability, based on an evaluation of the 'person beyond the illness', another shift of emphasis appears. This is a change from an all-or-none philosophy engendered by thinking in terms of indications and contra-indications, to a more flexible attitude made possible by the consideration of criteria of suitability. For example, this approach permits one to consider that some patients who have had schizophrenic symptoms might be suitable for analysis and

that some neurotics would not be suitable (Greenson, 1967).

A trend noticeable in recent discussions is the emphasis placed on criteria of *unsuitability*. This makes for an assessment of suitability by exclusion, i.e. any patient would be regarded as suitable for analysis unless proved otherwise. However, such a selection bias may operate to create an idealization of the psychoanalytic treatment method and lead to its employment where more suitable alternative methods of treatment are available. Hartmann & Kris have posed a challenge by pointing out that the decision 'as to in which cases psychoanalytic therapy is not indicated, in which it should be modified, and in which it is the most promising or only possible therapy', depended on the degree to which 'genetic insight' was thought to be a therapeutic asset in any particular case (1945). By 'genetic insight' they refer to an understanding, usually developed by the patient in the course of the analytic procedure, of how his condition in the present

has derived from his past, and has extended into and affected his current life.

In conclusion, it appears to us that the further clarification of criteria of suitability for psychoanalysis, and an emphasis on such criteria (as opposed to 'indications') may clarify some of the problems of selection. In contrast, the use of such vague and tautological concepts as 'analysability' may serve to obscure them. However, it should be stressed that the criteria mentioned in this paper constitute no more than a part of the total set of factors which enter into determining suitability for psychoanalysis. Many other criteria are used by the experienced assessor, and a significant proportion of these have not been fully verbalized in the literature on the topic.

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Uses and abuses of child psychiatry: problems of diagnosis and treatment of psychosocial disorders

By J. H. KAHN*

Every clinician is given or assumes authority within boundaries which depend upon his possession of a body of theoretical knowledge, competence in what he undertakes, and a discipline which implies rules with regard to what he does *not* do.

Psychiatry is a specialty within medicine, but its boundaries, which ensure its identity and which distinguish it from outside professions, have always been imprecise.

It is worth recalling that these themes find expression in the *Anatomy of Melancholy*. Burton apologizes for his presumption in dealing with this subject ('I being a divine have meddled with physick') but justifies himself by saying, 'It is a disease of the soul on which I am to treat, and as much appertaining to a divine as to a physician.' On the subject itself of his discourse, he refers to 'transitory melancholy... which comes and goes upon every small occasion of sorrow, need, sickness, trouble, fear, grief, passion or perturbation of the mind... Melancholy, in this sense, is the character of mortality.'

Nearly 350 years later Sir Aubrey Lewis (1946) covers the same topics, in discussing in general terms the inappropriateness of defining categories for disturbances which owe their nature to being part of the humanity of the individual concerned:

...the diversity of this widespread group of illnesses depends on their being disorders of mind - disorders, that is, of the human function which comprehend and sum up all other functions of the organism. It is only by ignoring most of what is individual in these illnesses that a few common types or categories can be recognized

comparable to the diseases of somatic medicine. Such a procedure is necessary for practical ends; material must be classified.

From this point, he goes on, as one must, to deal with mental illness within a classificatory system.

My own purpose will be to discuss the dimensions of diagnosis, and treatment, within child psychiatry, and to distinguish those where the psychiatrist has the main or exclusive responsibility from those where he shares the responsibility with others. These issues affect every branch of medicine in some degree, but child psychiatry provides the best example of the need to examine traditional concepts and to develop new ones.

Considerations of diagnosis should come first. If the child psychiatrist's work is to be coherent, he needs a comprehensive scheme that will enclose the whole range of disorders which are referred to him, and which he may, or may not, accept for treatment.

A small proportion of his work will fit into categories of specific disease entities which can be understood in terms of the traditional medical model. In such cases, there is the complaint, which is the symptom; an investigation, carried out by the psychiatrist who is sometimes assisted by colleagues in other professions; the diagnosis, which is a way of distinguishing the condition from other types of disorder; and the treatment, which is related in a rational way to the system in which the investigation is carried out.

The diagnosis can serve many purposes. (1) To recognize the disease entity which is separable from the normality of the individual and from other diseases. (2) To relate events to causes - the aetiology, and to effects - the pathology. (3) To predict the outcome - the

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prognosis, which is a matching of observation with previously recorded experiences. (4) To provide a basis for the selection of therapeutic processes. (5) To relieve anxiety – once a disease has been named, there is then no responsibility for further investigation. The value of naming a disease comes from the belief that what is named is understood. It must be this which accounts for the ready acceptance of a Latin or Greek translation of a simple descriptive word. Thus 'overactive' becomes 'hyperkinesis', and people go on to speak of a 'hyperkinetic child' and, without any further evidence, are ready to assume pathology and aetiology under the label 'brain damage'.

In a rational system, pathology, aetiology and treatment should be able to be conceptualized in a single theoretical framework. Rationality, however, is not always insisted upon. Many a procedure has been handed down to the present day by long tradition on no other basis than the fact that it works. Many such procedures are eventually found to have a rational basis, but it is too much to hope that everything which survives will have a validity confirmable by scientific study.

Some diagnostic and therapeutic systems are ideologies and not subject to proof or disproof. Those who have only one treatment for human distress have no need for diagnosis. Those who have only one explanation for disease have no need for investigation, and, with mental illness, there are many who have confidence in the equal efficacy of any kind of treatment, whether by trained or untrained persons: the argument probably goes thus: 'The illness is not organic, therefore it is psychological, therefore it is imaginary, therefore it is non-existent.' A current cynicism is that 'there is no such thing as mental illness: it is all in the mind!'

It is necessary to come to terms with the fact that mental illness requires a different conceptualization from that of somatic medicine. The rational principles of diagnosis need modification when applied to disturbances of thoughts, feelings, behaviour and

relationships. Aetiology is never a single cause; there are a number of components which operate within the matrix of the constitutional factors which we call the temperament. The present state must be related to past experiences in terms of beneficial and harmful events; deprivation must be related to provision, and it may also be necessary to speculate on the way in which crises at various developmental stages can make an individual more vulnerable or more resistant to present stress.

In order to consider all these factors, a new dimension of diagnosis (Kahn, 1969), different from that of specific diseases, needs to be invented.

This dimension is that of *disorder of function*. The question here is not whether a person has or has not got an illness. Rather is it the question of which activities or performances are adversely affected.

Most chronic diseases, whether of soma or psyche, fit into this second dimension.

There is yet a third dimension – that of *deviation from a statistical normality*. This applies particularly to behaviour which is considered to be abnormal and also to some clinical syndromes which are merely an intense form of an experience common to all humanity. In this third dimension the complaints are relative to the culture, to race, religion, colour, social class, geographical area, and the epoch in time in which one lives. What is normal or abnormal varies from district to district, from generation to generation.

The consideration of these three dimensions has implications for treatment.

For *specific diseases* we think in terms of cure, and the responsibility is purely medical.

Disorders of functions enter into various living activities and the treatment is shared by those who have skills in particular areas. A child lives and grows in the family, in the school, in the neighbourhood. Other professional services are involved with his individual, family, and educational life. *Expression of the disorder is multidimensional, the causation*

multi-factorial, and the treatment multidisciplinary. It is proper to speak of intervention in any single area as 'treatment', and thus we have remedial education, speech therapy, physiotherapy, as well as psychotherapy. At the same time, the child and the family might be involved in receiving the benefit (or otherwise) of administrative, legal, religious, and environmental social services.

In *deviation from the normal*, particularly where behaviour is concerned, there may not necessarily be a medical contribution at all. The treatment may be purely legal or social action. The aim is to bring the behaviour into conformity. An alternative aim might be to enlarge the public tolerance of the behaviour which is described as abnormal. In such instances, the psychiatrist may have an educative function as when reporting on a single case or, in his public role, when he takes a share in the shaping of popular opinion.

The deviations are not the exclusive domain of the child psychiatrist and many problems of thoughts, feelings, and behaviour are neither medical nor psychiatric until someone makes them so. The psychiatrist comes into the study of some human problem only by invitation, and this invitation may not be wholehearted. It is as if the psychiatrist is expected to claim authority in every problem of living, only to have that claim challenged even while his help is being sought.

It is therefore necessary for the child psychiatrist to discipline his thinking and not to use diagnostic terms without first considering the dimension in which the disorder is being presented and observed. He should also refrain from offering any treatment which is unrelated to the theoretical system in which the diagnosis is made. Abuses arise most frequently when the psychiatrist uses descriptive words as if they were the equivalent of specific diseases. One hears of a child described as 'suffering' from separation, deprivation, rejection, maladjustment, delinquency, as if these words were the equivalent of conditions in adult psychiatry such as

anxiety, depressive, phobic, obsessional states, and psychoses. Even these latter conditions are not diseases but syndromes which take their label from a predominant symptom, and the disturbances cover a wide range of feelings which enter into many areas of personal and interpersonal experiences. The position is even worse with regard to treatment. The confusing array of therapeutic processes and recommendations has developed as part of the hotch-potch of diagnostic categories.

An attempt has been made to introduce order into the classification of mental disorders in psychiatry on an international basis (Rutter *et al.*, 1969). An immense labour was undertaken by psychiatrists, representing different countries, in seminars organized by the World Health Organization, to provide a basis for comparison of observations. In a seminar which was held in Paris in 1967, 'Psychiatric Disorders in Childhood' was chosen as a subject, in order to develop 'a useful and scientifically sound system in child psychiatry that would be acceptable for international application'. The diagnostic exercise was based on the study of case histories and video-taped recordings of interviews. It became obvious that compromises had to be made in order to reach some agreement. Semantic differences existed, and it was agreed that a glossary of terms would be an indispensable feature of any satisfactory classification. There was disagreement where there was overlap between disorders. The final formulation was in a tri-axial classification. The first axis was the clinical psychiatric syndrome, the second axis the intellectual level, and the third axis consisted of associated or aetiological factors.

The clinical psychiatric syndrome emerges as a grouping of fundamentally different diagnostic concepts, which include different levels of observation based respectively on unrelated theoretical structure. The classification includes the names of symptoms and syndromes which were given a standing equal with more abstract concepts such as *adaptation*

reaction, specific developmental disorders (with eight subheadings varying from hyperkinetic disorder to enuresis, tics and stuttering), *conduct disorder, neurotic disorder, and psychoses*. *Neurotic disorder* stands alone, but there are four subheadings of *psychoses*. Next there follows *personality disorder, psychosomatic disorder, and other clinical syndromes*. Finally, there is the manifestation of *mental subnormality only*, although this could be given a place in the second axis if associated with a category otherwise included in the first axis. The third axis also includes data which overlap the content in the categories comprising the first axis.

It is stated that the classification should be based on what are called 'solid clinical facts' (whatever that means) and it was hoped that it would be put to the test by being adopted by psychiatrists in different countries prior to re-representation in 1975.

This heroic undertaking to provide the basis for the psychiatrist is an attempt to give an agreed clinical label to each problem which confronts the child psychiatrist. It was stoutly affirmed that the child psychiatrist is a clinician, and therefore his work should be brought into the medical tradition by being given diagnostic labels in clinical terms.

The child psychiatrist, however, has a complex social role as well as a medical one; and many of the disorders can be brought into the medical system only by a distortion of their nature and by a denial of some of their components. No matter how the psychiatrist labels the disorders which he is called upon to treat, he will be faced with calls for help on behalf of children affected by family disharmony, social maladaptation in the parents, and pressures of inappropriate educational programmes.

There will be many problems where it will be a matter of choice as to whether the appropriate intervention serves the individual personality of the child, the interaction within the family, or the environmental circumstances which surround the child and the family. In many of these problems, the psychiatrist

comes in as a partner of, or a consultant to, some other agency which is carrying the main burden.

The child psychiatrist cannot and should not exclude himself from participation in the understanding of all these problems, but, in many of them, his authority is no greater than that of the teacher, the social worker, the policeman, or the minister of religion. There are some problems on which he is consulted and on which he makes a response, not from his knowledge derived from his training as a doctor and a child psychiatrist, but from both the wisdom and the prejudices of the untrained part of his personality.

It is an abuse of child psychiatry to bring medical authority into any activity in which disciplined medical procedures have no part.

Respect has lingered for medical authority which is so important where there is responsibility for matters of life and death, and frequently there is an over-eager readiness to accept a psychiatrist's prescription to remove a child from one school to another, from one home to another, or even to take him permanently from the care of his parents. The decisions may be essential – even vital – but the techniques of investigation may be as much appertaining to the psychologist, the social worker, and the representative of the legal system, as they are to the physician.

The psychiatrist should not allow himself to be excluded from the wide range of treatment which is available from medical and non-medical colleagues, but neither should he expect his views to be uncritically accepted by all the other professions who have a continuing responsibility in the life of the child.

I wish to refer briefly to a few of the frequently used therapeutic systems, and to some of the clichés that hide the loose thinking about them.

The term 'play therapy' is one example. In some child psychiatric or child guidance units, 'the multidisciplinary approach' is ostensibly fully accepted. Interviews are conducted by psychiatrist, psychiatric social worker and psychologist, the case discussed,

but there is only one available decision – whether or not to ‘take on’ this child for ‘treatment’. Treatment in such a clinic is understood to be a standard commodity.

We have cases suitable for treatment instead of treatment suitable for cases.

It would be wrong to criticize those who are dedicated to a single system, because such devotees are responsible for much of the progress in psychiatry. Pioneer workers can afford to select patients suitable for their treatment, and exclude those not suitable; but psychiatric units which have a responsibility for a catchment area need to develop or invent techniques to serve all the identifiable needs of their area. Thus there are some clinics which have responsibility only for those who cross the threshold of their premises, but those which are organized on the basis of geographical area have to carry some degree of responsibility for the total population of the area.

Some treatment methods stand out as examples of a theoretical viewpoint. Axline (1964) describes ‘non-directive therapy’ based on the assumption that the individual has, within himself, not only the ability to solve his own problems satisfactorily, but also a ‘growth impulse’ that makes mature behaviour more satisfying than immature behaviour. For that reason, she does not conduct any diagnostic interview before therapy and states that ‘regardless of symptomatic behaviour, the individual is met by the therapist where he is’.

At the opposite pole is Escalona (1964), who writes on ‘suppressive psychotherapy’ as opposed to ‘expressive’, from recognition of the fact that

psychotic children, by definition as it were, show extreme weakness in ego functioning and, at times, a disintegrative process which appears to interfere with ego development. Hence these children have failed to repress the psychic experience which normally should be unconscious.

These two extremes represent different viewpoints on the nature of personality and its disorders.

Labels have been attached by different individual therapists to some particular medium through which communication is channelled. It is necessary to challenge the use of the name of a medium along with the word ‘therapy’ in a way that implies that each label refers to a different system of treatment.

‘Play therapy’ is the most familiar combination of words to describe treatment. The child is given a free choice in the use of material, which includes small toys, either specially constructed or drawn from the goods available in the toy shops. He has also freedom of choice in the manner in which this material is used. Differences exist in the extent to which the therapist participates or makes interpretations. This is the system which parents have in mind when they ask the therapist, at the first meeting, ‘What will he do?’ and if the therapist’s answer includes the word ‘play’, the next question is ready at hand: ‘How will that help?’

‘Play’ has its meanings, and its symbolization, which can serve the multiple purpose of establishing the relationship, of revealing conscious and unconscious mental processes, and also providing a topic for the exploration of the child’s capacity to vary the way in which different situations can be met.

Structured activities on their part can permit active expression and development of skills in manipulating objects and ideas, and in acquiring controls. Complete non-direction, acceptance, and freedom never exist. The session has its beginning and its end, and those who hope that a child can act out his conflicts, and get rid of aggression, are assuming that aggression exists in finite amounts. They may discover that there is plenty more where that came from!

Many therapists who have acquired skill in the use of some medium, such as art, drama, or puppets, have given their practice distinctive names such as art therapy, drama therapy, puppet therapy, in a manner comparable with the label ‘play therapy’. The happy accident which helps one child is

deliberately reproduced with another, and the therapist may be grateful when the unpremeditated use of some material gives rise to a new insight. The child's reaction to the budgerigar in the waiting room, to an aquarium, to contacts with the secretary – all these may receive notice and become grist in the therapeutic mill. To give labels to fortuitous enlargement of techniques is misleading. It implies that these proceedings are repeatable, like the prescription of a drug. Valuable as the description of such techniques may be (Levinson, 1964; Frick, 1965; Woltmann, 1951; Rodan, 1963; Kameny, 1964), each one should be examined as to how the procedure employed is related either to an ordinary developmental need (which might have been supplied elsewhere), or to a mental activity which is abnormal and which requires treatment. Replacement of some parts of the normal provision which have been deficient may well be therapeutic in its effect, but it does not necessarily require a psychiatric setting for its administration. Confusion has arisen because it has frequently been the psychiatrist who has discovered deficiencies in what should have been offered in the home and the school and elsewhere.

The name *psychotherapy* should be reserved for processes requiring skill in application and which are capable of definition. The name should be used discriminatingly and it should have its own purposes and mode of operation. The psychotherapeutic process can be discussed under headings of five components (Kahn, 1960): (1) the relationship; (2) communication; (3) interpretation; (4) insight; (5) utilization.

The relationship underlies the remaining four components. It includes the transference relationship, positive and negative, which patient and therapist bring to the encounter. The patient has his images and expectations derived from previous fantasies and experiences. The therapist, on his part, is not entirely a passive observer but has his own involvements, which include irrational elements. The therapist differs from the patient

in being professionally aware of this, and in being able to discuss it with the patient in relation to events in the therapeutic session. The relationship also includes the working agreement which depends upon the actual perceptions and experiences of one another.

Communication is verbal and non-verbal, and, like the relationship, is a two-way process. The therapist makes comments and asks questions, and the patient's communication will flow more freely when the therapist's contribution gives an indication that he understands what the patient is telling him. It is the understanding that turns communication into therapy.

Interpretation is the adding of meaning on to meaning. It does not depend upon a stock knowledge of the symbols which are currently used, nor is it a translating of ordinary language into psychiatric jargon. It is not interpretation to tell the patient, 'That's what you think you mean; what you really mean is...' The patient's original words and behaviour have as real a meaning as the new meanings which the therapist provides; neither is absolute, and neither is more real than the other. The therapist has knowledge of unconscious processes and is thus able to increase the number of ways in which thoughts, feelings, and behaviour can be understood. It is also interpretative to complete what the parent or child has only partly said. The following is an example of this. A mother, with arms akimbo, when invited to 'tell me something about the problem', replied, 'I have told this story a half-dozen times already', and then followed this with a defiant silence. The therapist continued her words in the same melody, '...and not got much help'. This immediately produced her story. The therapist's interpretation of her remark was accompanied by her interpretation of the completion of it. It was as if the therapist was promising that *here* she would get help. That is the danger of permission to communicate and of interpretation of the communication. It becomes a promise to

help which must be kept, and it should not be lightly made.

Insight is the new power gained by the patient to bring together a number of different ways of understanding his behaviour. It is not knowledge, in itself, of the unconscious processes which are normally inaccessible; it is the linking of these unconscious processes with conscious thoughts. The therapist, therefore, must help the patient to give utterance to the undisclosed part of the communication. When the patient concentrates on the past he is asked, 'What effect is it having now?' When the patient dwells on some immediate hurt, he is asked, 'On what occasions has this happened before?' Insight relates present and past, conscious and unconscious. Insight thus depends upon access to unconscious processes, but it is misleading to think that it is insight when a patient communicates, at the first interview, at a level which is associated with the later stages of deep analysis. These same fantasies are commonplaces in insanity, and therefore such communications at an early stage are a bad prognostic indication.

Utilization is the final process in the treatment and takes place not in the therapist's room but in the patient's life. The results of treatment are made evident in the patient's capacity to alter the circumstances which previously restricted his behaviour or performances.

Psychotherapy, as defined above, is made rational by the assumption that there is a psychopathology which underlies disorders of function and of relationships. If it is assumed that a neurosis is dynamically a defence against anxiety, then neuroses will differ structurally from one another according to the stage of psychosexual development which the individual has reached when some disturbance takes effect. Thus there are refinements of diagnosis and treatment within psychotherapy.

Behaviour therapy, in contrast to psychotherapy, is a form of treatment based on the assumption that any unsatisfactory beha-

vioural experience is, in itself, the illness and that it is not a symptom of some underlying state. It takes for its inspiration the particular theory about learning that has arrogated to itself the label 'learning theory'. This is based on the study of responses to identified stimuli. Some behaviour is reinforced, some inhibited, at the discretion of the therapist. Phobias may be replaced by compulsions and vice versa. At least, the treatment is based upon *activity*, and it is expected to lead to an alteration which is observable. In this respect it compares favourably with kinds of treatment which are supposed to lead to an alteration of an inner state without external evidence of that state.

Drugs have their effects on body function. Some act directly on the central nervous system, having an overall action or a selective action on the chemistry of the nervous system. Some drugs are sedative and induce sleep, or damp down general activity; some are stimulants, promoting wakefulness or giving a feeling of well-being. Sedatives and stimulants have been combined in a single preparation. The drugs which have selective action enter into close combination with the nerve cells, and effects are therefore far-reaching. Their administration is a serious matter. These drugs are used to alter mood, activity, and the experience of distress, and may be effective for this purpose. Their action is not specifically related to any physical pathological process peculiar to mental illness, nor to any aetiological factor. The physiological, pathological and aetiological basis of insanity is almost completely unknown. The claims made on behalf of drugs are even more far-reaching than their acknowledged powerful effects. Some drugs have been described as being indicated for 'behaviour disorders' or for 'enuresis', as if either of these were single entities. Another drug has been widely advertised in the medical press as 'anti-psychotic'. Drugs may have good effects and bad effects on the total experience of the patient, but it is a fallacy to describe the drugs used in mental disorders

as having effects and side-effects. They only have effects!

Likewise, it is a fallacy to compare the results of psychotherapy, behaviour therapy, and drugs. No two techniques can be compared with one another, not even two different drugs, because the effects are in different dimensions of human activity. The comparisons, even in a double-blind experiment, are scientifically valid only if the effect is directed to a specific pathological process which can be identified and observed. Whatever treatment is employed, it is a duty to describe what those effects are – beneficial or otherwise – without using the language applicable to experiments with drugs which have actions directed to some ascertainable pathological process in the specific disease entities of traditional medicine.

The therapeutic repertoires in child psychiatry are by no means exhausted, and *family therapy* is the most recent claimant for attention. It has existed in some form within child psychiatry since the time when parents were brought into the treatment process. It began with an attempt to study the background in which the child appeared to be disturbed. Latest developments, however, go beyond the provision of treatment for the child and case-work for the parents, and even beyond ideas of separate psychiatric treatment for the different members of the family. There are many different systems now of family therapy, and some of these depend upon rearrangement of the family circumstances in order to benefit the child and bring indirect benefits to the other members. It will be a different dimension yet again of family therapy to look upon the family group as the unit of normality and pathology. In this case, one would direct treatment to the *family process* and not to any of the members, singly or collectively. *Conjoint family therapy*, which could be carried out by a multidisciplinary team of workers in simultaneous contact with the whole family, works by questioning the ways in which one member of the family is singled out as different from the rest. In the therapeutic process, family

legends and stereotypes are challenged, and the similarities and differences of the members are redistributed.

If there is a connecting thread through the systems of diagnosis and treatment, it is that the child psychiatrist shares in the value system of his culture and sometimes seeks to change it. He responds to assignments given to him by others. He never sees a patient unless someone else has seen him first. Someone else carries the complaint in the form of a request to the psychiatrist. It may be made by a parent, a teacher or member of the staff of one of the social services, or by a court of law. It may come from a member of another branch of the practice of medicine. The child psychiatrist is asked one of the following questions. (1) Can you change this child so that he can fit into the pattern of what we expect, i.e. remove the symptom? (2) If you cannot remove the symptom, can you remove the child, i.e. get him into a residential school, children's home, hospital, or some penal institution? (3) Can you tell us how *we* should act in order to remove the symptom or the child? Rarely is he asked to join others in examining the whole process in home, school, or hospital in which the child does not fit.

Different processes pass under the name of treatment. Some are directed to a specific pathology. This is clearly in the medical tradition, and the responsibility is undoubtedly that of the psychiatrist. Some are directed to making good what is lacking – giving provision to the deprived. In this case, the treatment is that of supplying one of the components of the primary process of provision:

(a) Nurturing, which is the physical care and which includes physical love. This provides for physical growth.

(b) Teaching, which is the bringing to the child of perceptions of the external world of people, objects, and ideas about them. This provides for intellectual growth, which depends upon the possession of a vocabulary with which to represent people and objects in their absence, and in which abstract ideas

about relationships can be manipulated in the mind.

(c) Training, which is the setting of limits. This provides for social growth, and depends on the do's and don'ts which are subsequently represented by the rules of conduct inherent in both the social customs and the legal code of a community.

These three processes bring the existing adult world to each new generation, but standards change and civilization alters. Each generation creates new patterns of living by making selections out of the profusion of stimuli that are available, and by creating original patterns of performance. Therefore, in addition to nurturing, teaching and training, there is a fourth process, which is that of experimenting. The adult world validates the creativity of the child by approving and structuring the results of experimentation.

There are implications from these different processes with regard to therapeutic systems. Parental care may be supplemented or substituted by professionalized care. It may be the parents who mobilize the additional provision, but the organized community, acting through the local authorities, may take over the responsibility of the care of the child from the parent. Some aspects of medical and nursing care are an extension of the nurturing.

Teaching, which in a primitive society is a part of the family life, is professionalized in a more complex culture within an educational system. Teaching has a therapeutic counterpart in the processes which are directed to intellectual appreciation of faulty techniques of living and the substitution of more appropriate ones.

Training begins in the home and has its extensions in a judiciary and in the statutory powers through which obligations are enforced and prohibition imposed. The psychiatrist may take some share in defining limits and interpreting the difficulties in adaptations within society. Behaviour therapy is a particular example of the provision of a stimulus from which a particular response is expected.

Experimenting is a human phenomenon beginning in infancy when alternative ways of behaving are tried out. When it is envisaged as rebellion, it is discouraged by punishment; when it is perceived as originality, it is rewarded and encouraged. Experimenting is represented by the child's preference for one kind of food and refusal of another, and it continues as selectivity in the use of objects and words. Thus, even in the mistakes and wrong uses which become jokes, it is fostered by the giving of value to an unanticipated response.

Psychotherapy of some schools utilizes each therapeutic encounter for the creation of that which did not previously exist in the mind of either therapist or patient.

These different systems which child psychiatrists employ have their prototypes in widely differing fields of human enterprise. Some processes resemble the curing of diseases in the manner of traditional medicine. Some represent the carriers of basic nurturing, which is essential to the growth of the child. Some therapists, again, are like teachers, and some represent the discipline which emphasizes correct behaviour. There remain those who seek their results in activities which have no pre-existing blueprint. This level of activity may be more closely related to the inspiration of great artists than of conventional scientific observers, but if an activity is to be introduced into professional practice it must become formulated and disciplined. There is a part of the therapeutic process which stems from the belief that human beings can influence one another for good and bad, and the faith that the good exceeds the bad. Unorganized help that man provides for his neighbour needs to be brought into the systematic professional knowledge which can be transmitted from colleague to colleague and from generation to generation (Kahn, 1965). This knowledge can consist only of that which has an outer expression in observable behaviour. Yet, at the same time, many people are convinced of the reality of an inner experience of relationships between individuals.

How can we find words to describe this inner consummation? With the philosopher Wittgenstein, we must admit: 'that whereof we cannot speak, thereof we must consign ourselves to silence'.

It is the poets who have the imagination to find the words which bring together the experience of the heart and of the conscious

mind. John Keats, in one of his letters, which foreshadowed the poem about truth and beauty, said:

I am certain of nothing but holiness of the heart's affection and the truth of imagination. What the imagination sees as beauty, must be truth. . . . The imagination may be compared to Adam's dream - he awoke and found it truth.

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Psychopathological considerations of a case of recurrent manic psychosis*

By PING-NIE PAO†

Greatly influenced by Kraepelin's conceptualization of manic-depressive psychosis, early psychoanalytic literature regarded melancholia as the primary illness and the manic psychosis as secondary to it (e.g. Freud, 1917, 1921; Abraham, 1911, 1924; Rado, 1928; Klein, 1935, 1940; Fenichel, 1945, etc.). Representative of this view is Abraham's (1924) statement: 'In "pure" mania, which is frequently of periodic occurrence, the patient seems to me to be shaking off that primal parathymia without having had any attack of melancholia in the clinical sense.' (From the context, Abraham had obviously used 'primal parathymia' to connote depressive illness rather than depressive feelings.)

Deviating from the above trend, Lewin (1950, 1959) understood mania and melancholia as two parallel states, selected by the ego to meet the inner conflict between instincts, superego and reality. He stressed that mania is neither the after-effect of the running of a course of the circular or cyclic psychosis nor an ensuing defensive reaction to the melancholia. In a previous clinical report (1968), of a patient who showed mania and melancholia alternately, my study of the causative factors in the transition of states led me to the same conclusions as Lewin. Mania and melancholia are indeed two parallel states, which can be reactivated under similar yet quite different circumstances. When suffering from a disappointment in the object, the patient experiences great mental pain. This pain is a complex affective experience; it is an admixture of unbearable feelings of helplessness

and hopelessness described by Bibring (1953), of tension resulting from an insuppressible urge to discharge aggressive impulses, and of guilt derived from the superego censuring against its discharge. To eliminate this painful experience, the mental apparatus resorts to a best adaptive solution (Sandler & Joffe, 1969) or effects a realignment within the defensive organization of the ego (Lichtenberg & Slap, 1971). The process brings about regression and loss of later learned ego functions. As reality-testing becomes impaired, boundaries between the internal and external experience become obliterated and the shape of the representational world (Sandler & Rosenblatt, 1962) is disturbed. The patient associates the disappointing contemporary object with the infantile 'bad' affect and attempts to flee from it. If a new object is not available – by available it is meant not only the physical presence of the object but also its willingness to be libidinally responsive to the patient – the patient has to 'stay' with the disappointing 'bad' object and the melancholia results. On the other hand, if a new object is available, the patient takes flight to the new object, succeeds in 'shaking off' the 'bad' object or 'bad' affects, makes use of 'good' affects to eliminate the 'bad' affects and simultaneously identifies with the idealized omnipotent primary object (the idealized 'good' mother) – this constitutes the manic psychosis.

In this paper, through the presentation of the first six years' treatment of a patient with recurrent manic psychosis, I hope to demonstrate that the manic illness represents an attempt to undo separation-individuation through identification with the idealized omnipotent primary object. I shall also, in the

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ensuing discussion, speculate on the fixation point to which the manic patient seems to regress. It must be stressed that the primary concern of this communication is restricted to psychopathological consideration of the presented case. While the final step that leads to the manic symptomatology might well be biochemical, it seems, as I indicated before (1968), that what initiates the biochemical changes in the body lies in the psychological and emotional factors.

Since little has been written about the psychoanalytic treatment of mania (or of cyclic psychosis in general), I shall sketch in chronological order the patient's first six years of treatment. In this way, I aim to reaffirm Abraham's belief and optimism that psychoanalysis is 'the only rational therapy to apply to the manic-depressive patients' (1911). This point of view should not be affirmed without full recognition that significant problems are invariably encountered in the treatment* of manic-depressive patients, especially in the early phases. The patient's resistances toward analytic work are intense and the symptoms are tenacious and recurrent. Since exposure of his repressed conflicts often means a recurrence of disabling and painful symptoms, the patient would likely try everything in his power to resist the treatment in order to preserve his immediate well being. While severe relapses at the time of the return of unresolved

* For the manic-depressive patients, even in totally 'normal' interims, a preparatory psychotherapy is necessary to first consolidate a working alliance. Abraham's failure to characterize the difficulty in the early phase of the treatment would lead one to believe that it is very easy to get such a patient into *analysis* during the 'normal' interval. Rosenfeld (1969) seems to imply the same when he said: 'modifications in analytic technique are particularly common in the approach to schizophrenics but not in the work with manic-depressive patients. That is probably one of the main reasons why the number of descriptions of psychoanalytic therapy with manic-depressive patients is comparatively small compared with the extensive literature relating to the treatment of schizophrenia.'

conflicts must be envisaged as part and parcel of the treatment and not as a lack of progress they can dampen the incentive to go on with the treatment on the part of the patient, his responsible relatives as well as the analyst.

CLINICAL MATERIAL

The patient's husband, Mr A., called me and made arrangements for me to see his wife, who was not yet 23 but had already been hospitalized three times in the previous three years.

Mrs A.'s father was described as being fastidious, busy and distant and a mere austere image in the mind of his children, especially Mrs A. Her mother was described as being very pretty and always gay and carefree; she was said to have consumed alcohol in excess. Perhaps by parental encouragement, as well as her own need, Mrs A. had a tendency toward twinning with her next younger sister, 18 months younger. Mrs A. was born four weeks prematurely. The premature birth was brought on when her mother was affected by her own father's unexpected death. Mrs A. was breast-fed by her mother briefly before she was turned over to the care of a series of nursemaids. Not quite one year old, Mrs A. sustained a lachrymal gland and duct infection which resisted cure until an operation was performed when Mrs A. was 12 years of age. The eye condition gave Mrs A. the nickname of 'the pus eye'. This taunt was associated with feelings of humiliation, shame, anger and badness, but the same eye condition brought her close to her mother as it elicited her pity, guilt and caring.

Always a shy, weak, compliant person, Mrs A., at 12, some months before her menarche, suddenly became boisterous and rebellious. When she was barely 15 she was madly in love with a boy. In order to terminate this relation, the parents sent her to a distant boarding school for girls. There she felt 'bad', singled out, lonely and sad and had suicidal ideas. Soon, however, she 'forgot' her sadness, became 'a ray of sunshine' and found herself new suitors on the campus. Following graduation she chose to enter nurse's training, soon as she was confronted with sick patients, especially those in the children's ward, she became so distressed that she was no longer able to concentrate on her studies. Again, she 'forgot' her distress by becoming the dormitory glamour girl with the most dates. She became pregnant and

fled to another city. After the pregnancy was over, she returned home, but was obviously not quite herself. She fell in and out of love with one man after another and she fought with her mother constantly. As she grew increasingly confused and disorganized, she was hospitalized. Diagnosed as manic-depressive psychosis, manic phase, and given no shock treatment or tranquillizers, her condition remitted in six months. Very soon after her discharge from the hospital she met and married her husband. One year later, a boy was born. The childbirth was followed by another manic episode – only 11 months after the first hospitalization. This second hospitalization lasted for 7 months. However, only home for 6 months, Mrs A. became manic again following a period of extreme anxiety and desperation in taking care of her son, who by now was about one year old: she was readmitted to the hospital for another 6 months. Upon discharge from this third hospitalization, she was recommended to come to see me.

In the next six years I saw Mrs A. as an office patient. During these six years, because of the necessity to hospitalize her due to her recurrent manic psychosis* our work was interrupted three times, each time for 6–8 months. Thus I shall characterize the therapeutic work as first, second, third and fourth periods, respectively.

TREATMENT

First period (10 months)

At our first meeting Mr A. accompanied Mrs A. to my office. After he had made all the business arrangements (she merely sat and stared), he withdrew. It was evident that Mrs A. was uncomfortable at being alone with me. She was then 22. Despite her sophisticated manner, she looked very girlish, hardly her age. She told me that the doctor in the hospital and her husband had told her to come and see me. She herself saw no such

* For various reasons I could not follow her while she was psychotic. Freud (1898, p. 283) said, 'During mania or melancholia, nothing can be affected by psychoanalytical means.' Abraham (1911) also said, 'Analysis cannot be carried out on severely inhibited melancholic patients or inattentive maniacal ones.' I have indicated before (1968) the value of working with the patient during the psychotic period.

need. Upon further questioning, she indicated that perhaps she had problems in taking care of the child, but these problems had been resolved in the discussions she had with the psychiatrist in the hospital. Of course, she was curious as to why she had to be in mental hospitals, but she was also puzzled as to why everyone should make a big to-do about the past. She believed that she would never again need to be in a mental hospital. As to the real reason which made her consent to see me, she said it was because she needed my permission to have more children. Her husband, she said, had told her that childbirth made her sick, and that they would have no more children until I said she could.

She came to me regularly and always on time. During the hours she always found something to talk about. But what she talked about was the minutiae of her daily routine and gossip. In her behaviour, it was obvious that, while she was compliant on the one hand, she was always subtly rebellious; but when this was pointed out to her, she literally could not understand what I was talking about. Essentially she was always in a cheerful mood. Occasionally she appeared listless. If I questioned, she would tell me with all sincerity that she was about to catch a cold or have indigestion, or give another explanation equally devoid of interpersonal significance.

Seven months after the beginning of treatment she arrived at her hour one day visibly upset and said that she was pregnant. While fearful that upon the birth of the child she might become sick again, she insisted that she had to have another child since her younger sister had just had one. Now, suddenly, she became quite a different person. No longer chatty, she talked non-stop about her previous childbirths and psychosis; hardly was there any time to be concerned with her need to compete with her sister and her feeling about doing things against her husband and myself, referring to the conversation during our first meeting during which she said her husband forbade her to have children unless I said so. She became increasingly anxious and three

weeks later she had a miscarriage. A few days later, when she could return to my office, she reported she was having trouble in going to sleep. In the course of the hour she suggested that I change the upholstery of the furniture in the office to brighter colours. She said that the original colour was making her feel sad, which she did not like. When I mentioned her recent sad experience, she broke down for a split second, saying, 'What do you want me to do, cry? I am sad. If you want me to cry, I will. But I'd rather forget the whole business.' In subsequent days she behaved as a clinging child toward me, calling me at odd hours because she felt lonely and wanted someone to talk to, while acting at home as a seductress toward a family friend. She rapidly lost her grasp of reality and was hospitalized again.

Second period (6 months)

When she returned to me 8 months later she told me that she had come to me this time because she wanted to and not because of her husband's coercion as she had done previously. I must stress that while at one level she was more serious toward treatment, at another level she was not as 'psychologically orientated' as she was just before the miscarriage. Her old defences of denial or repression were working again. In the main, every hour continued to be introduced by her reports of minutiae and gossip. Unlike the past, she now occasionally showed curiosity about her own behaviour; but her ability to explore was limited.

Some 2 months or so later her son was scheduled for a tonsillectomy. She began to collect data from others whose children had had tonsillectomies. Her chief concerns were whether the operation could be dangerous or if the post-operative course would be smooth. When asked why she had to introduce this topic in every conversation, she confessed that although she knew she trusted the doctor, she felt strange taking the doctor's word too seriously. She recalled feeling the same way about her mother during the months she had helped her after her childbirth. Further

exploration of her mixed feelings toward the persons she depended on was curtailed by her return to her preoccupation with the tonsillectomy procedures. Following her son's operation, she went back to gossiping for a while. In response to any close-to-conscious level of interpretation of her behaviour, she became gradually more 'psychological'. She talked more about self and about her immediate family members. She was then relatively free from anxiety in looking after her son, about 3 years old now. She talked about her own inability to cope with her husband who, in her opinion, drank too much and who, because of his habit of drinking, tended to neglect her. On her own, she moved on to talk about her mother who also drank. No sooner had she spoken of her mother as being selfish, fun-loving and not caring for her children, especially herself, than she became psychotic within a few days, and had to be returned to a hospital.

Third period (11 months)

Six months later, when Mrs A. returned to me, she seemed to behave quite differently during the hour. There were fewer items of gossip and fewer abrupt changes of subject. As she recalled where she left off before her psychosis, she started to talk about her husband again. At times she referred to her parents but in general she showed neither the interest nor the capacity to make connexions between the present and the past.

Mrs A.'s husband agreed to let her paint the living room and promised to move the heavy furniture for her, but after several reminders he failed to do so. Mrs A. dragged a sofa away from the wall herself, thereby scratching the floor. When her husband complained, Mrs A. instantly became angry, turned around and slapped the paint brush across his face. Being extremely frightened, she avoided looking at her husband. Later, when they talked things over, it came as a surprise to her that her husband had in fact apologized. As she spoke of this experience, she became aware of her fear of her own

destructiveness and that this fear of hers made her agreeable and compliant to others.

One of her great-aunts died. Mrs A.'s mother called Mrs A.'s husband and asked him to screen the news. Mrs A. became very angry after learning what her mother had done. Following a brief period of agitation, she became critical of herself for being unappreciative of her mother's consideration.

When her younger sister became pregnant again, Mrs A. became quite perturbed. She spoke of wanting to have another child but felt that she should not have one yet for she might get sick again like she did the last time. She was resentful since she felt her sister was always getting ahead of her. Although she was 18 months older than her sister, they were in the same class and shared a coming-out party. She recalled with feelings of humiliation that she and her sister were mistaken for twins. This led to a review of the circumstances of her fourth episode of manic psychosis, i.e. her need to become pregnant in order to be twinning with her sister.

Mr A. reached a quick decision on buying a larger house which he considered an 'unsurpassably good deal'. Within one week after closing the deal they moved to the new home. In the hours, she spoke of her frustration from the problems that go along with packing, unpacking, relocating things, etc., and her son's frequent nightmares and crying for unlocatable toys. Just about the time when she began to talk about her rage against her husband, who left her out in making the decision about the purchase of the house, she received a phone call from her mother informing her that her father had a 'blood clot' in the leg, was hospitalized a week earlier and was on the way to recovery. Immediately following the phone call, Mrs A. held the belief that her father was dying and accused herself of being responsible for his ill health. Within days she became very manic and was rehospitalized

Fourth period (24 months)

Mrs A. was in the hospital for 6 months this time. When returning to me, she reviewed

the events that led to her last psychosis. At first, the complicated emotions following the moving, including the loss of the old house and old neighbours, were considered as the major factor of her mania. Some time later she recalled the telephone calls from her mother and became quite angry with her mother for asking her husband to screen the news of the death of her aunt and for keeping the news of her father's hospitalization from her for a week. Still some time later, she realized that her husband, like her mother, tended to keep things from her, e.g. not discussing with her the purchase of the house before the deal was completed. 'What do they think of me? A baby?' Although she became instantly guilt stricken, she could not attempt to understand her guilt feelings. Out of this exploration she concluded that 'It seems whenever I get angry at my mother and my husband I become frightened, guilty and psychotic.' It was still not possible for her to consider what role she might have played in encouraging them to treat her 'like a baby'.

Her husband's 17-year-old niece came to visit for a week. At 17, this niece struck Mrs A. as being composed, self-sufficient and self-confident. She knew her own mind, unlike Mrs A., who had always complied with the wishes of her mother and other senior relatives, sometimes agreeing to run errands for them even when their requests conflicted with her own schedule. Speaking of herself at 17, Mrs A. was full of horror, regret and resentment that she had been so self-destructively rebellious, while simultaneously so overconcerned with others' opinions of her.

Mrs A. and her husband decided to have another child and she soon became pregnant. She herself, as well as her family members, feared that she might become psychotic again after the childbirth. Many hours in treatment were devoted to the discussion of her previous experience of childbirth. In the course of the discussion the most important event that evolved was her mourning for her son, born out of wedlock. I sympathized with her that it must have been an extremely difficult

experience for her those days, since she could not ask for help and could not talk to anyone. She broke down and cried. She said, 'I feel very strange. I have not really cried since I was sent away to boarding school. Of course, I have often cried but that was because I was mad but not because I was sad. When I had the miscarriage, I felt very sad but I couldn't cry. I think if I had cried on someone's shoulder, I might have been all right.' This was perhaps her first acknowledgement of her inability to ask for help when she needed it.

Now she spoke more readily of her inner experiences. At the wedding of her cousin there was a large family gathering. She reported afterwards that she felt very ashamed of herself at the reception because she found herself 'feeling like a 12-year-old' and not knowing how to behave before so many senior relatives, except by passing the food and hanging on to her son. Exploration of her life at 12 led her to recall a series of sad memories of losses. The first was the death of her maternal grandmother, whose favourite Mrs A. had been. Shortly afterwards she had an operation on her 'pus eye' and she began her menses. In the same year she had been taken out of her own school and had joined her younger sister's class in a more prestigious school. In the reconstruction, she realized that it was following this series of sad experiences that she had adopted a devil-may-care attitude. Wistfully, she added that she was like her mother, who denied her sadness, wearing a smile all the year long.

Fifteen months after she resumed treatment with me this time, she delivered a full-term baby daughter. Apparently she was quite loving and efficient in taking care of the infant. When the child developed a diaper rash she was reminded of the time when her son had had a diaper rash. She described how she had felt helpless and wanted to ask her mother to assist. Because she feared she would become like her mother too much she had to reject her mother's help. This reopened consideration of her conflict over trusting the doctor who operated on her son, the analyst and others.

Mrs A.'s mother's sister died, and when Mrs A. was informed by her mother she felt very, very sad. That evening and the next day she declined to see anyone lest her sadness might dampen others' fun. When she talked to me she said that this was a very strange phenomenon, because she hardly knew her aunt, who had lived abroad most of her life. 'There was no reason that I should feel so sad for a relative stranger.' When Mrs A.'s mother returned from abroad, after attending to her sister's affairs, she called on Mrs A. They chatted, both were in a good mood. During her next hour Mrs A. reported, 'When I heard my mother's voice, I was worried whether I should feel sad or not. I was really happy when I found out that she was happy. I believe I was sad last time because she was sad.' As she talked she realized that she was always easily affected by her mother's mood. She added, 'We always felt the same way about things.'

DISCUSSION

Since 12 years of age the combination of instinctual push and distressful external events necessitated Mrs A.'s seeking the best adaptive solution (Sandler & Joffe, 1969) until she settled on manic psychosis as a solution. We are not in this paper concerned with the genetic factors that led to the choice of this particular solution. We should, however, like to consider what this solution accomplished for Mrs A.

Mrs A. had six discrete episodes of manic psychosis in less than seven years; the first three episodes were not closely studied while the latter three were. All six episodes were characterized by an acute onset of a regressive process in which various major ego functions became disorganized. Uniformly, the regressions or the disorganization were brought forth in circumstances in which Mrs A. had experienced extremely painful feelings. Prior to the first episode she had just returned from an eight-month exile in a new city where she had recently disposed of her new-born son and now, although among her own people,

she could not share with anyone what she had just gone through. Before the second, she was perhaps re-experiencing what she had gone through before the first episode. The third was triggered off by Mrs A.'s exasperation in dealing with her 12- to 14-month-old son, who became more and more self-willed. The fourth, in the re-experiencing of the painful emotions that preceded her first episode with additional distressful feelings, brought about by the competitive feelings towards her sister and by the miscarriage. The fifth, in the exploration of her feelings towards her husband and her mother. The sixth by her mixed feelings towards her husband and her mother plus the added inconvenience and distress associated with moving into a new house and leaving her neighbours.

A further examination of the clinical material, especially the fourth, fifth and sixth where careful scrutiny was made, revealed that through the manic psychosis Mrs A. seemed to be making attempts to resolve an unresolved conflict of being compliant and self-assertive at the same time, which, on the surface, manifested in the form of a dilemma of impossibility of pleasing two masters. Before the fourth episode she was caught up in the twin-like competition with her younger sister by becoming pregnant as had her sister. Her compulsive urge to become pregnant represented an unconscious continuation of her childhood compliance with her parents' wish (actually her own conviction) that she see herself in the demeaning position of being the equal and rival of her younger sibling. Compliance with this parental demand, however, necessitated defying her husband and her analyst and thus created for her a frightening sense of separateness from them. Before the fifth mania, she was on the verge of talking about her husband and her mother, which represented closeness and compliance to the analyst but established a sense of separateness from and disloyalty to her husband and her mother. Before the sixth mania she had been making strides towards establishing her self as a separate entity. Her husband's and her

mother's implicit message that she was too 'small' to participate in the decision of purchasing the house and to face the news of the death of her great-aunt and the illness of her father threw her into conflict about complying with the husband's or the mother's wish for her to be small and with the analyst's wish for her to grow up (her own strivings that are projected on to the analyst). Beset with the conflict of pleasing one of the two masters, representing opposite interests, she resorted to manic psychosis.

During the last two years of treatment Mrs A. became increasingly capable of a collaborative effort in exploring her compulsive need to match her affective and ideational experience with that of the important love object. For instance, she agreed to run errands for her mother, her husband, her mother-in-law, etc., only to discover after she left them that this conflicted with her own schedule. The most striking example was her discovery of matching her mood with that of her mother's during several phone conversations following the death of her maternal aunt. Compulsive matching of her feelings and thoughts with those of the important love object eliminated, although temporarily, the boundary between the self- and the object-representations. In this process, frustration, rage and anxiety were the common result. Frustration and anxiety generated feelings of being apart; feelings of being apart spurred the need to reunite with the important love object; the reunion obviated self and caused further frustration and anxiety. In order to break this vicious cycle, manic psychosis became the best possible solution. For during mania, she became outspoken, did not care what others said or thought and over-emphasized her self-interest. The pseudo-strength was the result of an unconscious identification with the idealized, primary love object. Thus, in mania, she accomplished the compromise of having a sense of separateness from the primary love object while being one with it. In comparison, the obliteration of the boundary between the self- and the object-

representations during her period of compulsively* matching her affective and ideational experience to those of the important love objects, and during manias, is only a matter of degree and duration.

From the analysis of the events that preceded her manic psychosis and the transference manifestations, we may conclude that Mrs A.'s struggle to reunite with and to separate from the important love object indicated a conflict that remained unresolved from her early separation-individuation phase. Mrs A. was born prematurely and was nursed by a grief-stricken mother for a while. She was then in the changing hands of a series of nurses. Before she was one, she suffered from a chronic infection of her lachrymal glands and was supposed to elicit her mother's attention through this ailment. These events constituted ego strain and paved the way for regression and fixation (Sandler, 1967). At 18 months her younger sister was born. There was no detail as to the mother's care for the infant, nor the patient's immediate reaction to the birth of the sister. But at a later date there was ample evidence of the patient's attempt to establish a twinship with her sister which was in turn encouraged by the parents. This twinning added impetus to the pull to regress.

Let us conjecture where, in the developmental line, was the fixation point to which the patient regressed. In her study of separation-individuation processes Mahler (1963a, b) indicates that the autistic and the symbiotic phases are followed by the hatching period which begins by the fifth or sixth month and signifies the beginning of an unavoidable, predetermined growing away from the previous states of 'oneness' with the mother. Mahler (1966) further indicates that the practising period begins by the 10th or 12th month. 'There begins a steadily increasing libidinal investment in practicing motor skills and in

exploring the expanding environment, both human and inanimate' (p. 158). During

the practicing period and during the period of mastery, which continues well into the second half of the second year, individuation proceeds very rapidly, on the one hand, so that the child exercises independence to the limit. On the other hand, along with the acquisition of primitive skills and perceptual cognitive faculties, there is a clearer and clearer differentiation of the intrapsychic representations of the love object and of the self. . . Just around the time of mastery, [the child] reaches the high point of his mood of elation, which is buttressed by his sense of his own magic omnipotence [pp. 160, 169].

This is the time a basic mood of elation is crystallized; 'elation seems to be the phase-specific characteristic or basic mood during the practicing period' (p. 158).

In 'Elation, Hypomania and Mania' (1971) I have made the observation that the toddler of the practising period behaves very similarly to a manic patient in terms of his mood elevation, his sense of magical importance, and his motor over-activity. During the practising period the toddler shows sufficient and yet incomplete differentiations of the intrapsychic representations of the love object and of the self. There is a constant to-and-fro movement in the union and separation of the intrapsychic representations of the self and the object. Because of these general similarities and because of Mrs A.'s history of an eventful life during the 10th to 18th months (protracted eye infection, changes of nurses, birth of the sister), I venture to speculate that in the case of our patient, Mrs A., the fixation point that she regressed to corresponded to the practising period *par excellence*. The fact that Mrs A.'s third manic episode followed her difficulties in dealing with her 12- to 14-month-old-son, right in the middle of his practising period, seems to further suggest that the struggle of Mrs A.'s son during the practising period stirred up her own unresolved conflicts.

It is generally accepted that early anxieties can intensify and prolong the tendency

* This compulsion underlines the 'compulsivity' trait of the manic-depressives, of which Cohen *et al.* (1954) and Smith (1960) speak in their papers.

towards internalizing objects globally and indiscriminately. In the case of Mrs A., since in the course of frequent changing of nurses the mother remained as a relatively constant figure, her importance was greatly fostered. Thus the mother could become the object to be globally internalized and to be fused with. As a result, Mrs A. became 'just like her mother'. And, because of this close identification with the mother, Mrs A. adopted, among others, the mother's defensive devices to cope with unpleasant affects. Like the mother, whose surface demeanour was one of constant gaiety, Mrs A. learned to use pleasurable affects defensively.* Perhaps this process of global internalization of the mother could be one of the contributing factors in determining Mrs A.'s choice of manic psychosis as the best adaptive solution.

Mrs A. averted her distressful feelings by adopting psychosis again and again. Unlike other manic-depressives, Mrs A. never had melancholic, depressive psychosis. We do not wish to speculate why this should be. Perhaps in the further course of treatment of this patient the answer may be revealed.

SUMMARY

In the above, I have presented the first 6 years' treatment of a case of recurrent manic psychosis. Through the study of the events that led to three relapses of manic psychosis during the first 4 years and the study of the last 2 years of

* According to Hartmann (1939, p. 30), 'we take over from others a great many of our methods for solving problems...thus arises a network of identifications and ideal formations which is of great significance for the forms and ways of adaptation'.

treatment during which there was no relapse, I have made the observation that prior to the manic psychosis there was an intensification of a struggle on the patient's part to reunite with and to separate from the important love objects. Consequently, mania may be seen as an identification (union) with the idealized omnipotent primary object and an attempt to undo separation-individuation. Viewing mania as related to the basic elated mood crystallized during what Mahler calls the practising period *par excellence* (9th-10th to 16th-18th month), I stipulated that the basic conflict of the manic patient was fixated at the practising period.

In attenuated form this struggle to reunite with and to separate from the important love object was consistently present in the patient. It contributed to the phenomenon of the patient's compulsive scanning and matching of her affective and ideational experiences to those of the important love object and probably was the original root of the 'conventionality', one of the characteristic traits of manic-depressives.

I have suggested that a close identification of the patient with her mother, whose surface demeanour was one of constant gaiety, might contribute to the patient's use of pleasurable affects to eliminate the painful affects; but I have no conclusive answer as to why this patient never did suffer from melancholic psychosis. It did seem that other patients, who had similar early experiences, developed circular psychosis.

In this presentation I have made an effort to describe certain hardships one might encounter in the early preparatory (to psychoanalysis) phase of the treatment of the group of patients which are grossly classified as manic-depressives. It must be noted that manic-depressive illnesses are here conceived as those with manifested psychosis either in the form of mania, melancholia or circular form, where major ego functions are temporarily and definitely suspended.

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Freud's 'Project for a Scientific Psychology': possible implications for contemporary psychology

By JOHN M. INNES*

Many psychologists have demonstrated the influence of Freud on psychology. Boring (1950) came to the conclusion that Freud was one of the 'Great Men' of psychology and certainly Freud's writings have influenced the thinking of all breeds of psychologists. The influence has been mainly in the fields of personality theory, child development and clinical psychology and where his ideas and concepts have not been adopted in their original form they have been modified, tailored to fit some other theoretical framework such as S-R theory. Such modification of course has its dangers. One can completely misinterpret Freud because of an overemphasis on secondary sources which may slightly alter and, in the process, distort the concepts. To find that some of these derivations fail to predict behaviour can be used as evidence against Freud's theories, but they may also be evidence against the transformation.

There has been a tendency for critics to show flaws in Freud's methods and to dismiss all of his work because of them, and this attitude has been common in recent years (e.g. Eysenck, 1961). Because of Freud's failure adequately to sample either from the population of patients or from their repertoire of behaviour and because of a tendency to over-generalize from these biased samples, there has been a rejection of his concepts and theories. When specific theories are adopted they are, to use Klein's (1959) phrase, 'banked off by heavy coatings of vitriol', and as a result may be misunderstood. Adelson (1956) also has suggested that the prevailing ideology in America has influenced the perception of

Freud's theories, producing a bias in the features which are abstracted.

Heidbreder (1940) saw Freud as having an influence from outside the general body of psychology, with psychologists paying attention to his work either because of his impact on the public generally or because of his terminology, his use of analogy, to describe the mental mechanisms. Heidbreder perceived Freud as like Darwin in his ability to set common observations in a new context but unlike Darwin did not present his theories in a form suitable for empirical test.

Hebb (1960) has also pointed to the failure of psychoanalysis to be really incorporated into psychology.

But psychoanalysis is still not part of the mainstream of psychological thought, and I think the reason is clear.

Psychoanalysis, as such, has shown no real interest in the mechanics of behavior: in the problems of learning, of sensation and perception, of concept formation, of the nature of mind or the validity of introspective data, and so on (Hebb, 1960, p. 736).

But Freud may be of more interest to psychology than has been previously accepted. One could argue that on Hebb's criteria behaviourism should not have been incorporated into psychology. Both behaviourism and psychoanalysis can be characterized as ignoring such obvious data as imagery (Holt, 1964). And in some senses Hebb is wrong in stating that Freud's psychoanalysis ignored much of central interest to psychology. A study of Freud's early career may have implications for the progress and direction of psychology. An attempt will be made here to show that Freud may have some lessons to teach modern

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scientific psychology, both from a reconsideration of some of his early work which may have fairly *direct* implications for some areas of modern research, and from a consideration of the development of his thinking which may have *indirect* implications for the attitudes of psychologists to their subject-matter, human behaviour.

Following Deutsch & Krauss (1965) we can divide Freud's theory of instincts into four related areas. These are: (1) the theory of the transformation of instinctual energy into derivative motivations and structures; (2) the theory of the structural organization of the personality; (3) the theory of the stages of psychosexual development; (4) the theory of consciousness.

It is the first three of these which have received most consideration in psychology, influencing as they have personality and developmental theory. And Freud's influence and reputation have been largely judged on what he said in these areas. The fourth, the theory of consciousness, has been largely ignored until recently, and it is this area that we shall consider.

Holt (1963) has given another classification of Freud's work, one which is helpful in the present context. The published work can be classified into three areas: (1) clinical theory, which was carried out throughout his life and which was concerned with the individual case in treatment; (2) general theory, the abstract theory of behaviour which involved the development of models for dream processes and normal behaviour in general, and which was largely limited to his early career; (3) phylogenetic theory, the history and development of man over long periods of time, as, for example, in 'Civilization and its Discontents' (1930) and 'Moses and Monotheism' (1939). This theorizing developed gradually and is mainly the product of Freud's later years.

The change from general theorizing began about the time of Freud's break from the influence of Wilhelm Fliess, who was audience and critic for much of Freud's thinking up to 1895. The main result of Freud's link with

Fliess was his 'Project for a Scientific Psychology'. The 'Project' was an attempt at a psychology of behaviour in general, not just of abnormal behaviour, and at the same time it incorporated physiology into the theory and made deductions of behaviour from a limited number of assumptions.

In the 'Project' is Freud's early theory of consciousness which attempted to explain a large portion of normal human behaviour. It has been largely ignored, overshadowed by the later work on psychosexual development. Freud himself largely abandoned the attempt to explain normal behaviour, except of course for dreams. The trend of Freud's work was for his models to become less and less adapted to empirical test (Holt, 1964). Whatever the reasons, the 'Project' is not even mentioned by Boring (1950), so apparently it did not contribute to his final evaluation of Freud's influence on psychology.

Following the break with Fliess, Freud began to write much more speculative material, being little tied down to the structural requirements of physiology, and inventing concepts on an *ad hoc* basis when required. This later work has been questioned because of its inconsistencies. But Freud himself acknowledged these inconsistencies. He seemed to be annoyed with the tendency of his followers to accept what he wrote as holy writ instead of understanding, criticizing and developing it. In 1923 Freud is quoted as saying (after being heckled about some contradictions in an early paper): 'This problem exists only because 30 years ago I wrote quite candidly, not foreseeing that at some future time every detail would be accepted and made sacrosanct to the last letter.' Fine (1963) presents other evidence supporting the view that Freud was aware of his inconsistencies and was not opposed to discarding parts of his earlier work.

It is an interesting question, which cannot be answered here, to ask to what extent the freedom from limitations of hypothetico-deductive theory enabled Freud to achieve the insights that he did. Holt's (1965) analysis

of Freud's cognitive style suggests that Freud was not really capable of rigorous proofs and so moved to a more congenial method of thinking.

Whatever the reasons, following the 'Project' Freud ignored physiology. He seemed to regard the physiology of the time as being unable to cope with a theory of behaviour (although almost certainly he expected a convergence at some later time).

But every attempt to go on from there to discover a localization of mental processes, every endeavour to think of ideas as stored up in nerve-cells and of excitations as travelling along nerve-fibres, has miscarried completely.

Although Freud gave up physiologizing, we must note that later writers (e.g. Pribram, 1962; Glick, 1967) have considered Freud's neurology in the 'Project' to be a very sophisticated model matching anything current today. The implications of both his physiologizing and his abandonment of it will be considered later.

FREUD'S 'PROJECT'

What did Freud say in the 'Project'? It was written in 1895 and never actually finished. When he lost interest in physiology Freud apparently dropped topics such as the psychology of the intellectual processes, which were associated with it. Attempts to account for normal processes such as attention seemed to be lost in his work on the neuroses and finally disappeared in his phylogenetic theorizing.

We will consider the section on normal psychological processes as it is this which can be most closely related to a study of associative processes. Although his formulation has implications for an understanding of abnormal behaviour and his physiology is very modern we will not consider these in detail, other than is necessary to understand his terminology.

Freud identified three main systems of neurones to explain behaviour: (1) what we

would now call the specific projection system, the nerves from the sensory receptors; (2) what he called the nuclear system, networks of neurones stimulated by the projection systems and by internal receptors; (3) the cortical system which mediated the perception of stimuli, the appearance of consciousness.

The nuclear system is from our point of view the most important. It is in this network of neurones that Freud sited the *ego*. The neurones in this system are characterized by a constant cathexis, i.e. non-propagated neural excitation which leads to transmitted excitation only under special circumstances. Cathexis seems equivalent in fact to facilitation. Such a constant cathexis alters the passage of excitation between neurones and makes possible the facilitation, and the inhibition, of excitations from the projection to the cortical systems.

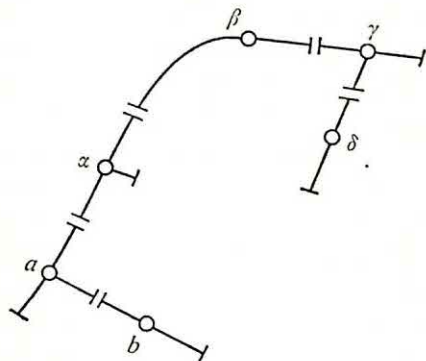


Fig. 1. Hypothetical neurone system.

In Fig. 1, for example, a neurone α with a constant cathexis can direct the transmission of an excitation presented through neurone a to the system β , γ , δ , instead of directly to neurone b . Thus α can inhibit transmission to b by preventing excitation of b . If, as in Freud's example, b is a key neurone (i.e. a secretory neurone) for unpleasure, then the system has prevented the sensation of pain or fear.

The idea of cathexis enables Freud to introduce the concept of attention. Attention is a pre-cathexis of the perceptual neurones arising from indications of quality in the cortical system. Quality arises from the trans-

mission of frequency of excitation which for Freud is transmitted without inhibition at the contact barriers between neurones (synapses) unlike quantities of excitation. Indications of quality intensify the pre-cathexis of the perceptual neurones and so the course of a perception can be guided through the network of the nuclear system. If there is no pre-cathexis then the excitation will pass along a path of least resistance and will split up, eventually becoming too weak to be transmitted further, unable to overcome the contact barrier between neurones.

Now there is a need to introduce a process whereby the ego can guide the course of excitation as a result of past experience, i.e. the capacity of the ego to learn to attend. Pre-cathexis requires the presence of indications of quality and these do not appear during the process of association, they only arise from perception. Quality arising from the passage of quantity, however, can be produced by a discharge of quantity which gives rise to a report of movement. Freud introduces speech associations, linking of neurones in the nuclear system with neurones of auditory images which are in turn related to motor speech-images. So if a memory image is cathected or stimulated and this is accompanied by reports of a discharge these are indications of quality, and also indications of the memory being conscious. So a pre-cathexis of these verbal images can lead to the discharge of quality. Freud introduces the idea of *conscious, observant thought*.

A similar notion appears in his paper on 'The Unconscious' (1915). 'A conscious idea comprises a concrete idea plus the verbal idea corresponding to it, whereas an unconscious idea is the concrete idea alone.'

The indications of quality are not essential to thought. Freud admits that there may be a very common thought process in which indications of quality are never, or only occasionally, aroused, due to the ego following the course of association with cathexes automatically. This is conscious thinking with unconscious intermediate links, which can,

however, be made conscious. These 'intrusions' into consciousness are what we might call free associations.

Indications of quality are very valuable, however. Attention to quality ensures the impartiality of the course of association. The ego has wishful cathexes which may influence association, and a protection against such bias is the direction of quantity to indications of quality which cannot produce such diversion. To quote Freud in this context from the 'Project':

Thus, thought which is accompanied by the cathexis of indications of thought-reality or of indications of speech is the highest and most secure form of cognitive thought-process.

In summary, what Freud is proposing is a tripartite system of: (1) A projection system which filters external stimuli and transmits excitations to the nuclear and cortical systems. (2) A nuclear system which is characterized by non-transmitted excitation. (This latter system is a network of neurones which can facilitate or inhibit the passage of excitation which arrives from the projection system. This system is the neural basis of the *ego* and the processes of memory and attention can be accounted for in terms of this network.) (3) A cortical system which is stimulated by the frequency characteristics of excitation in the nuclear system.

The appearance of consciousness is the result of an interaction between the projection and the nuclear system, for example something being recognized because it matches some memory of past excitation (although Freud is not able to account for the judgement process).

The consideration of some sections of the 'Project' has been brief and selective. Can a study of this work help us at all in modern psychology? We will consider Freud's relevance to modern work in two ways: first, implications for current research on cognition, and secondly, implications for any trends to physiologizing which may exist at the present time.

IMPLICATIONS FOR CURRENT RESEARCH ON COGNITIVE PROCESSES

The principal area in cognition on which Freud has had an impact has been in verbal behaviour, especially work on word associations.

In their classification of types of research on word association Hunt & Cofer (1944) identify four main modifications of Galton's method. One of those is the method of continuous free association, attributable to Freud. Two others are Jung's analysis of 'blocking' and the emotionality of words, and Kent & Rosanoff's classification of words as common or uncommon. But Hunt & Cofer were looking at Freud's method of continuous free association as an approach to the aetiology of mental deficit rather than as a measure of the deficit itself. They do not consider the possibilities that emerge from study of the structure of consciousness as suggested in the 'Project'. It is only recently that research in verbal behaviour has attempted to study structural relations of the type Freud appeared to be concerned with.

Deese (1966) presents a theory of associative meaning that bears some similarity to Freud's, and Deese includes a critique of the dynamic theorists' approach to the study of word associations. If we look at the work of Jung (1918) we find an analysis of word associations into such categories as egocentric, supraordinate, contrast. Such work attempts to construct norms of various classes of response for various categories of subjects and little of interest has emerged. Freud himself paid little attention to Jung's method.

Later writers have looked at uncommon associations, the associations that have 'slipped through' the ego defences. According to Deese, however, a study of *common*, rather than deviant, associations can enable us to construct a picture of the structure of word associations. Deese himself considers that such a picture may have implications for psychoanalytic theory, and he may be right, especially as Freud's early picture of behaviour is very similar.

Other work on word association behaviour arouses feelings of similarity to Freud's theorizing. Baldrige & Hustmyer (1965) have presented evidence of a clustering effect in the continuous associations of clinical patients. They found a tendency for associations to converge on some word which was of emotional significance for the patient. Fosmire (1965) did essentially the same thing with a sample of normal subjects. He found that subjects with low commonality scores on the Kent-Rosanoff list tended to converge or focus on words that were more highly polarized on an evaluative dimension. The words they were 'attracted' towards were of more emotional significance with an increasing number of trials.

This work gives the impression of authors utilizing Freudian notions of free association without acknowledging the fact. Research on word associations has begun to look at the structure of associations existing among groups of words and since Freud's picture of consciousness in the 'Project' is also one of structure, perhaps a study of the early work may benefit us in several ways.

Current models of word association processes emphasize the networks of associations which may govern memory, free recall and problem-solving (e.g. Deese, 1959, 1966). If we ignore for the moment the physiological basis of Freud's theories, then we might regard the neuronal nets as akin to networks of verbal associations. For Freud changes in the passage of excitation from one neurone to another could be altered by the direction of attention to that association, i.e. by a pre-cathexis of the association. Work on the priming of word associations uses a similar idea. Storms (1958) has shown that word-association responses of low commonality can be significantly increased if the response words are presented prior to the association test. Freud also suggests that the direction of attention to associatively related words should have the same effect, i.e. in a network of associations the cathexis of a number of associations will increase the likelihood of a particular memory

in the neighbourhood being produced. Cramer (1965) has shown a slight tendency for the presentation of associatively related words to cause the 'hub' word (the word that is related to the several different words) to be recalled as having been presented as part of the original list of words.

The effect is not very powerful and occurs only when subjects are given intentional instructions to learn. The effect is more powerful when there is direct priming, as in the Storms experiment. The possibility remains of individual differences, both in the density of relationships between words in the associative networks and in the extent to which bonds can be cathected by prior instructions, i.e. the potentiality to 'priming'.

Nevertheless an effect can be demonstrated. Verbal behaviour theorists have taken a long time to rid themselves of the notion of simple serial associations of stimulus and response and to take on the concept of networks of associations. Within the verbal behaviour literature there is still controversy over the best way to characterize the process and product of verbal learning. Peterson (1967), for example, introduces the need for an 'editor' (a 'censor'?) in work on memory. Even when verbal learning theorists introduce the need for structural relationships between words (e.g. Marshall & Cofer, 1963) they still rely on the terminology of S-R theory and this can introduce unnecessary problems into the field (cf. Kiss, 1968). One is hesitant to suggest that experimental psychologists would have arrived at the concept much earlier had they certainly he expressed ideas that in the present climate of opinion might well help in understanding cognitive behaviour.

Rapaport (1960) has over many years attempted to construct a theory of structure, based on Freud's work, which can stand as a general psychological theory to account for normal behaviour. While psychoanalytic theory has no theory of learning as such it does possess the origins of one in its theory of

consciousness. Rapaport (1960) and Schwartz & Schiller (1967) report studies which stem from such a general theory. Russell (1963) also points to the relevance of ideas of attention cathexis to studies of selective processes in word association.

As Rapaport (1960) points out, the theory of consciousness is not a drive-reinforcement type of theory, hence many attempts to make the drive-reinforcement theories appear relevant to psychoanalysis seem misguided. Although reinforcement theories have seemed capable eventually of explaining everything (Miller, 1959), perhaps the current climate of opinion perceives cognitive and other approaches as being fruitful in explaining behaviour (Koch, 1964). In a situation where a type of psychoanalytic theory can be seen as contributing on its own terms rather than via translation into a different language, then more may come from a study of Freud than has been apparent up to the present.

The problem remains, of course, that Freud's theories do not allow of direct test and in that sense are not scientific, but his theories may have heuristic value in fields other than the ones he has influenced, such as clinical psychology.

As a final example of the potential importance for hypothesis generation that Freud's theories may have, Steiner (1966), using a concept-formation task, demonstrated that Freud's attention-cathexis model better predicted the use subjects made of cues presented during one part of a task which later became relevant to solution of a later task than did, for example, a mathematical model for concept attainment proposed by Bourne & Restle (1959). Freud's 'model' emphasizes the subjective relevance of cues presented during the task with the subsequent cathection or de-cathection of these cues by the subject, whereas Bourne and Restle view a cue as relevant if the experimenter has defined it as relevant, imposing this view on the subject. Freud's theories had definite heuristic value in the generation of empirical tests.

IMPLICATIONS FOR TRENDS TOWARDS
PHYSIOLOGY IN CURRENT PSYCHOLOGY

In 1947 Skinner regretted the trend towards explanations of behaviour in terms of physiological processes. His paper had little effect, as in 1958 he still felt constrained to note an emphasis on physiological explanations (Skinner, 1959*a*). Skinner has argued that behaviour is an acceptable subject-matter in its own right and does not need reductive explanation. One does not think of Freud and Skinner as having much in common, but they may both be arguing for a similar position, although for slightly different reasons.

Freud was originally a neurologist and he had made a considerable reputation before his studies of hysteria. In the 'Project' he attempted to give a physiological model for behaviour and this model has stood the test of time well. However, Freud started from a study of *behaviour*. His data may not have been gathered by methods acceptable at the present time, nevertheless he looked at how people acted. He was unable to account for the observed behaviour solely in terms of the passage of neural excitation so he introduced the concept of contact barriers or synapses just as Sherrington did but he also introduced the idea of cathexis, of graded, non-transmissible potential.

Now Sherrington has had the greater effect on experimental psychology. With his isolation of the reflex, psychologists were able to produce physiological evidence for the concepts of stimulus and response, or rather took the term stimulus and response from physiology. Although of course Sherrington's picture of the nervous system was not as simple as this, additional concepts of excitatory and inhibitory states being introduced, psychologists turned to the 'building-block' method, starting with the simple reflex and hoping to build up to more complex behaviour. Criticisms such as those of Dewey (1896) seem to have had little effect on the development of psychology at this time.

Freud was attempting to analyse behavioural

concepts such as association and memory and trying to find, in the 'Project', reductionist explanations in a few neurophysiological concepts. He was building a 'conceptual nervous system', and apparently it was quite sophisticated even by present-day standards. Even so, several things could not be explained in these terms; for example, the judgement of identity between a previously established memory trace and input. Freud's direction was not from the simple to the complex but rather he started with complex behaviour and found it necessary to invent a physiological system to account for the behaviour that he observed, albeit in a restricted population and in the restricted setting of dyadic interaction between patient and therapist.

Hebb (1951, 1958) has criticized psychology for being tied to an early physiology and for not turning to current research on graded potentials, etc., and he did demonstrate a certain myopia among psychologists during the 1930s and 1940s. During this time there was a reaction against physiology and a turn towards the study of 'behaviour', but in fact the 'facts' of behaviour that were discovered were based on a physiology of the 30 years from 1890 to 1920. The neurone theory did much to accelerate understanding of behaviour, as shown by Hebb (1951) and Murphy (1949) among others, but it did have negative effects in that it limited psychologists' attention to certain features of behaviour such as stimulus and response connexions with the neglect of such things as relationships between stimuli. In fact, Lashley (1924) has criticized Freud for slipping in an implicit physiology in his writings, although Lashley preferred to refer to it rather as 'psycho-hydraulics'. Lashley was presumably not talking about the 'Project' but rather about the later motivational psychology.

Freud was not limited to a narrow version of neurophysiology. His picture of the nervous system used concepts that had not been tied down to direct observation. Physiology was used to explain observed behaviour and

not *vice versa*. Hebb has also built a 'conceptual nervous system', but while he has continually modified his model, Freud abandoned his attempt and did not, after 1895, tie down his hypothetical constructs to physiological events.

Freud and Skinner are not alike in their attitudes to the study of behaviour. While they both concentrate on the study of behaviour Freud does introduce hypothetical constructs (and he has been criticized for this by Skinner (1959*b*)) and he did expect that physiology would provide a substrate for the explanation of behaviour. Nevertheless, they both do study *behaviour*.

Early physiology led psychologists into blind alleys of controversy, such as that between Hull and Tolman in the 1930s. Hebb (1951) argues that this can be avoided by keeping abreast of physiological theorizing and research. But, remembering the limitations of the human being as an information processing device, perhaps psychologists might understand more by ignoring physiology, both implicitly and explicitly, and developing constructs for the explanation of behaviour when the data requires it rather than when a physiological model requires it.

Present-day psychologists may well learn something from a consideration of Freud's treatment of behaviour and its relationship to physiology. When he explicitly formulated a physiological model, Freud modelled the physiology on the behaviour to be explained, rather than *vice versa*. The result was a very robust physiological theory which seems to have stood the passage of time well. When he abandoned physiology after the 'Project' he concentrated on the behaviour and threw light on numerous problems, opening up new

conceptions in the understanding of abnormal behaviour which in turn aided in the understanding of normal development. An implicit acceptance of physiology hindered certain areas of psychology during its development. In the case of Freud, explicit rejection of physiology aided understanding. The focus was behaviour, with the physiology having to fit the behavioural data. Although Freud was undoubtedly a genius, perhaps all psychologists have something to learn from this case study.

CONCLUSIONS

Pribram (1962) has shown the relevance of Freud's early work to modern psychophysiology. A study of Freud's 'Project for a Scientific Psychology' does provide the basis for a consideration of Freud in a fresh light. While acknowledging his influence on clinical psychology, a study of the 'Project' might well show that general experimental psychology can learn something of value. Both a study of his physiological model and a realization of his *abandonment* of such a model might aid contemporary psychology in its study of behaviour.

Freud can be regarded as a psychologist, rejecting physiology completely, trying to branch out with new techniques to study the behaviour of a particular group of people. Boring (1950), in appraising Freud, spoke of him as being 'the greatest originator of all, the agent of the Zeitgeist who accomplished the invasion of psychology by the principle of the unconscious process' (p. 743). Freud can also be looked at in another innovative role, urging psychologists to study behaviour rather than physiologically founded models.

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Stereotyped aggression in a group of Australian Western Desert Aborigines

By IVOR H. JONES*

The Australian Western Desert Aborigines live in a harsh environment and much of their behaviour appears to have an immediate and direct survival value for them. It is probable that this behaviour has remained constant for a substantial time, although for precisely how long has not yet been established.

It seems to the author that striking analogies exist between the mechanisms for handling aggression in these people and mechanisms in lower animals, which have, over the last 30 years, become the subject-matter of ethology.

Some concepts possessed in common by ethology and other disciplines have been used in earlier studies of these people; for example, Basedow (1925) differentiated between intra-group and inter-group fighting. The observations made here are not entirely new: descriptions of similar fighting patterns have been recorded by Basedow (1925) and Warner (1937), among others, but their observations were made from a different frame of reference. This paper is intended to draw attention to behaviour among a primitive people which appears to be readily understandable in ethological terms. It is not intended to claim that the behaviour described here is homologous with that found in animals.

SOCIAL SETTING

Man has lived in Australia for at least 25,000 years – probably longer (McCarthy, 1970). It is not known for how long the Western Desert people have been socially adapted to the region, but there has probably been little change in their behaviour for some thousands of years. They have acquired patterns of

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behaviour which allow them to live in a peculiarly adverse environment without even such simple tools as a bow and arrow. Aggressive behaviour is prominent and talk of fighting and punishment figures substantially in their discussions. Kaberry (1939) talked of the 'clan', 'groups' or 'horde' as the basic unit. This small group probably numbered 20–50 when groups were nomadic and, according to her, was the smallest unit with a common territory. Warner (1937), when discussing Aborigines in Arnhem Land, accepted Basedow's description, and he too considered that the fighting pattern was different within the small groups and outside them; these small groups had a language and social organization in common with larger groups. 'Clan' or 'group' is now a less valid concept since these small units are amalgamating, but it is probable that the type of fighting described here, from personal observations, is traditional intra-group fighting which is now sometimes found among groups larger than those existing in nomadic times.

Now most desert Aborigines congregate around missions in numbers between 50 and 600. Within these larger groups small ones still exist. Within groups, disputes arise over sexual matters, from infringement of tribal lore or from actual or believed physical assault. Unlike Western societies, with the exception of weapons, property is mostly communal and offences against property are rare.

OBSERVATIONS

During 1967 and 1968 visits were made to remote Aborigine communities bordering on the Western Desert of Australia. The people discussed here were camped around Missions

at Warburton Range (26° S., 126° E.), Jigalong (23° S., 121° E.) and Fitzroy Crossing (18° S., 126° E.).

At Warburton Range, when disputes occur between men they are frequently settled by ritualized spearing. Between women they are settled by ritualized clubbing. Rarely a man may spear a woman, but a woman will not spear a man. Clubbing between men is known at Warburton, but none has been seen by the author. Among men clubbing seems to be an inter-group rather than an intra-group form of fighting.

Spearing. The offended person walks about the central area of the camp in a belligerent manner, making throwing movements and declaiming loudly. He usually carries spears, spear thrower and boomerang. The emotional level is high. His anger may be redirected on to an observer if the observer interferes with the display, but he will throw stones rather than a spear at him. The haranguing soon draws an audience, which is sympathetic to one side or the other in a predictable way, depending on family ties. These supporters often carry their own weapons and give profuse verbal encouragement, but no physical support. The demonstration may die away at this stage, particularly if the other protagonist does not parade in front of the group, but it may be renewed again a few days later. Alternatively, the two principal protagonists become more excited and each makes throwing movements with his weapons. This phase may culminate in the aggrieved person thrusting or throwing a spear at the other; the speared person in turn thrusts or throws one back again, and the aggressor has a second thrust so that, in all, three blows are struck. Thrusting is more common than throwing. The spear is always aimed at the thigh and penetrates the muscle mass over the inner aspect to a variable extent, the tip sometimes passing right through the muscle. Spearing above the thigh is strictly contrary to tribal lore. Spears may be barbed or unbarbed. The dispute ends when both parties have been injured. In the Warburton area about 90 per cent of the ini-

tiated men had spear scars, some as many as five. Only one death and one severe injury resulting in amputation were discovered over a 10-year period. Both these sequelae probably resulted from severe damage to the femoral artery. Wounds usually heal well and persistent infection is not common, even though the spear is dirty and further injury may occur when the spear is removed.

In other Western Desert areas where spearing is prohibited and weapons, if found, are confiscated, spearing has not been confined to the thigh when fights have broken out. In one area (Jigalong) where spearing is proscribed there have been Aborigine deaths; in this area women have speared other persons.

If a man spears a woman this is done for specific sexual contraventions of tribal lore and again a thigh wound is inflicted.

Clubbing. Clubbing in intra-group fighting in the Warburton area is exclusively a woman's way of fighting. Clubs are traditionally made of hardwood, 1½ in. or more in diameter and about 2 ft. 3 in. long; now crowbars are sometimes used. There is a preliminary demonstration similar to that described for men and the display may end at this stage. If fighting does occur the aggrieved person strikes first. She stands in front of the other and swings the club down with as much force as she can muster on the vertex of the other's skull, while the other stands still with head flexed, tensed to receive the blow. The initial blow is then returned without resistance and fighting continues without any clear order until one person gives up or flees.

Inter-tribal fighting. (Not personal observations.) This is now controlled and there is no evidence of recent outbreaks in the Western Desert. There is doubt about the extent of inter-tribal fighting in nomadic times. According to Berndt & Berndt (1964), it may have been quite infrequent. Warfare in the modern sense may not have existed, but periodic forays into the camp of other groups did occur to revenge a death or transgression of tribal lore by particular individuals in that camp. The victims were actually killed on

occasions, but even in this limited type of inter-tribal fighting there are instances of placatory gestures being used or of physical violence being replaced by verbal violence (Berndt & Berndt, 1964), or of one death sufficing to settle the conflict (Basedow, 1925), but under these circumstances ritualization of fighting was probably less common.

In the far north (Arnhem Land) feuds involved extended families for a substantial time (Warner, 1937), therefore approaching warfare but, again according to Berndt & Berndt (1964), this type of behaviour was probably not seen among Central Desert people, and even among the group described by Warner (1937), inter-group feuding was sometimes ended by a ritualized fight (Makarrata), involving dancing and spear-throwing to miss, with the younger men's exuberance being continually curbed by the older men. The ritual culminated in a spear jab through the thigh of the original aggressor.

Magic as an alternative form of aggression. Retribution for a wrong may be taken by magical means rather than by physical violence. This too is a highly ritualized procedure which has been fully described by Elkin (1964). The ritual is called 'boning' or 'singing'. The underlying principle is that a malign spirit is believed to be incorporated by magical means into the victim. Such acts are often, but not always, carried out in private either by the aggrieved person or by a sorcerer. They are not done indiscriminately, since the singer may himself be sung in retribution. The malign spirit may be 'removed' by other incantations, usually by a medicine man who specializes in such matters. We have found no way of determining how often magical practices are actually carried out, but preoccupation with magical matters seems to be more evident at Fitzroy Crossing where spearing is proscribed than at Warburton where it is not. However, the observation may be the consequence, at least in part, of cultural differences.

Syndromes apparently induced by magical acts. The usual traditional illness among these people has symptoms of pain or weakness as

the principal features; very occasionally death will ensue. Frequent reports of having been sung were obtained during psychiatric surveys (Kidson & Jones, 1968). These syndromes may be put into the usual psychiatric categories, but there are some syndromes which fit poorly and elsewhere these have been called traditional (Cawte, 1965).

Here the syndromes have been categorized in terms of cause. Some of them may be understood as the consequence of an aggressive act, while others cannot be understood in this way, but even when they are not the consequence of aggression they are explained by the victim in these terms.

Magic as an actual cause of psychogenic symptoms. Exceptionally a person may be seen to be sung, he may subsequently develop somatic symptoms – pain or incapacity – which in Western nosological terms would be diagnosed as hypochondriacal or hysterical (Kidson & Jones, 1968). Here a clear cause-effect relationship exists; the cause is the magical act, the symptomatology being psychogenic.

Magic as an actual cause of death. Very exceptionally the act may be seen and the victim may subsequently die. Such deaths have rarely been submitted to full medical and psychiatric investigation. From incidents reported to the author the clinical picture is suggestive of depression, but death as a consequence strongly suggests an organic component. The mode of death in those cases described to this author may be from pneumonia. The syndrome requires more investigations, since from an ethological viewpoint such deaths may be analogous to death from 'social stress' seen in rodents (Barnett, 1963).

Magic as a believed cause of psychogenic symptoms. Much more commonly a person may develop somatic symptoms which he attributes to a malign influence inflicted by some other person without such an act being seen to have occurred. He may have an actual or believed tribal reason for being sung, or have committed some transgression of tribal lore and in consequence provides the inter-

viewer with a culturally appropriate explanation for phenomena which would be understood quite differently in western terms. For example, there is a widespread idea that death may ensue from contact with the Feather Foot men or the Red Ochre men. These are secret organizations (which may well not exist at all) believed to come in the night without leaving tracks and inflict injury or disability, abduct or kill their victims in retribution or simply for the pleasure of inflicting injury. At Jigalong an initiated man ascribed his gross hysterical symptoms to this cause. In western terms, the syndrome consisted of mixed conversion and attention-seeking features consequent upon this man's losing his wife to another man. The tribal explanation was that the Feather Foot men had got the man. In this instance, therefore, a traditional explanation is invoked for a psychiatric syndrome.

Magic as a believed explanation for somatic illness. The person complaining of somatic symptoms which he attributes to magic may in fact have somatic symptoms of organic origin. For example, one patient at Warburton Range who complained of indefinite chest pains and provided an account of being sung which rested on inference rather than observation, proved to have pulmonary tuberculosis and subsequently died of the disease.

The first two examples are ones where aggression takes the form of magic rather than overt violence, while the third and fourth are not; however, all are understood by these people in terms of aggression.

Aggression as a prominent aspect of psychiatric disorders. During psychiatric surveys of Warburton Range and Yuendumu communities no evidence of suicide was found (Kidson & Jones, 1968). Depression did exist and formed 8 per cent of all psychiatric illness, but it seemed that when an Aborigine became depressed he would externalize his feelings – throw spears about indiscriminately – rather than internalize them. When this occurred, ritualization was apparently lost in that the thigh-spearing pattern was not adhered to, but reports of injury during these bouts of

seemingly indiscriminate spearing were rare. It may be that even here, where aggression was a consequence of an abnormal psychiatric state, the aggressors were throwing to miss.

Persons suffering from dementia sometimes used a spear indiscriminately. When this occurred, the behaviour was recognized as pathological by the group and these persons were either avoided or disarmed; they were not attacked in return. These variations of aggressive acts in psychiatric states may mean that aggression is released from its usual inhibitions by the particular pathology involved, and when this occurs it is to a lesser degree subjected to the ritualization which occurs during conflicts. However, it should be emphasized that the pathological nature of this spear-throwing act is recognized by the group. It does not usually result in a fight, even though this would have occurred had the original aggression been normal.

Placation of aggression. From an ethological viewpoint perhaps the most interesting placation, described by Meggitt (1962) and reported again at Warburton Range (Jones, 1969), is when two groups meet. It is then usual for a representative of one group to approach the other and offer his subincised penis for examination. (Part of the initiation ceremony among Central Desert people involves incision of the penile urethra, often throughout its length, the operation being known as subincision.) The organ is felt and, if it is appropriately incised and if he is in other ways acceptable, he and the group he represents are accorded hospitality. If the penis is refused it is offered to classificatory brothers; if they too refuse, the visitor must prepare to fight or run away.

A related behaviour is for a man publicly accused of a serious offence to try and put his penis in the hand of a classificatory brother. If the latter allows this to occur he undertakes to plead or fight for him. These 'sexual' gestures are, however, not the only placatory acts; others have been described by Meggitt (1962) and Berndt & Berndt (1964).

DISCUSSION

The basic Darwinian hypothesis of biological adaptation to the environment as a requisite for survival seems to be one which fits these communities well; for example, knowledge of hunting is an important part of childhood training, and a personal knowledge of water-holes in a person's home territory is a central part of the initiation process. Cawte (1968) has used the term human ecology to describe Aborigine behaviour in relation to his environment. A somewhat different frame of reference has been used here. An adaptation is described which is not only efficient but is similar to mechanisms seen in animals in similar situations.

The Aborigines are culturally equipped with the ability to kill by spearing, which has an obvious advantage for feeding. But if they used similar methods for intra-specific fighting they would soon destroy each other and thereby their community. With them, as among wolves, killing each other would confer a strong disadvantage on the group. Nevertheless, a means of settling intra-group disputes must be available; if sanctions against transgression of tribal lore did not exist, the lore, and therefore the way of life, would either disappear or change, and evidently this has not happened until recently. A means whereby spearing is used as a sanction without destroying the group is described here. The spearing is preceded by graduated threats, at first addressed to others rather than to the opponent, since a direct threat may precipitate actual aggression prematurely. It is then followed by a verbal altercation, accompanied by threatening gestures with weapons (these gestures may themselves be understood as stereotyped fighting behaviour) and finally by actual spearing. The dispute may be broken off at any stage. However, even though many fights do not progress to actual spearing, too frequent deaths of the contestants would still constitute a disadvantage for the group, and accordingly further stereotypy has occurred whereby spearing is confined exclusively to

the thigh where it is quite exceptional for an injury to cause death because only exceptionally are vital structures involved. Death from infection seems to be rare.

This apparent resistance to infection may itself be an adaptive phenomenon. Berndt & Berndt (1964) say that there is no evidence that these Aborigines have built up an inherited immunity to any infectious disease, but the group described here are known to have a high gamma-globulin level (Curnow, 1957). This is a plasma fraction involved in immune responses. It is at present uncertain if this globulin difference is the consequence of chronic infections or a transmitted trait, but it seems probable that whatever its cause it confers an advantage on the adult so far as resistance to this type of infection is concerned.

While the spearing behaviour described here is most prominent among Central Desert people an alternative stereotypy of intra-group fighting has been described in Arnhem Land, where migration from the north may have coloured early Aboriginal culture. Warner (1937) describes an intra-group form of fighting (Nirimaoi-Yolno) which consists of verbal altercations, followed by attempts to fight with spears while the combatants are restrained by relatives on both sides; rarely is anyone killed. In conservation of energy terms the aggressive force of the combatants is dissipated in attempts to free themselves from their respective supporters.

Women fight with clubs using a force which would probably crack the skull of Europeans. If blows were struck over the temporal region instead of the vertex, these blows would probably break the Aboriginal skull too, since the skull is not particularly thick in this region, but the blows are not struck over the temporal region. In the early stages of the fight at least, when greater force is used, the blows are struck in a stereotyped manner exclusively over the vertex. As Elkin (1964) remarks, the 'Aborigine is well equipped to withstand blows over the vertex, since the skull in this region is exceptionally thick'. He

is probably correct. Very little work has been done on this subject. Hrdlicka (1928) found the male Aborigine skull to be 6–8 mm. thick in the parietal region and the female skull was described as 'massive', when he examined their physical characteristics, but the author is not aware that measurement of the comparative breaking force of Aboriginal and western skulls has been measured.

A number of possible explanations exists: (1) a process of natural selection may have resulted in the elimination of those with thin skulls (a mechanism related to that postulated by Tappen (1970) to explain the great skull thickness of *Homo erectus*); (2) the existence of thick skulls has allowed the continuation of a form of behaviour which in others would soon have proved fatal to the group; or (3) just possibly they have found some trick of riding the blow. The former two seem the more likely. No evidence of the latter has been found, but close observation of women's fights by men is very difficult.

In an area where spearing is proscribed (Jigalong) an aberrant type of spearing is seen, suggesting that a rather delicate balance between an aggressive drive and its controlled release exists, and that when attempts are made to prevent traditional spearing a new type of dangerous, unstereotyped spearing occurs, which is more damaging to the group as a whole. At this stage such a hypothesis is no more than tentative but it may be a useful one to test in other communities where changes in aggressive behaviour are being imposed.

Adaptation of a food-gathering technique to serve an intra-group purpose by making it non-lethal is analogous to the modification of fighting behaviour in carnivores, whereby those with most reliable killing mechanisms have the most reliable inhibitions on killing in the intra-specific situation (Lorenz, 1966). A further analogy exists between placation of aggression in primates described by Wickler (1967) and placation among these people.

The most parsimonious explanation for the behaviour described here seems to be that it is a product of an interaction between the subjects and their environment rather than that phylogenetic continuity, and presumably therefore direct genetic inheritance, exists between Australian Aborigines and other primates, but it remains possible that genetic predisposition to these rather than other forms of behaviour exists.

The Aborigines have also evolved, in magic, a system which, among other functions, acts as a non-physical outlet for aggression. It is suggested that this alternative system is biologically satisfactory in that it maintains tribal lore by discouraging transgression, but is a threat to life only in rare instances. It acts, therefore, like spearing, as a homeostatic mechanism for the group.

The strong impression gained was that, where spearing was prevented by outside authority, magical behaviour was more prominent in Aborigine thinking. Proof of the point was not established, however, since an objective measure of magical acts having occurred could not be found.

It is suggested that ethological models may with advantage be applied to this community, without claiming that the behaviour described is homologous with that shown in lower animals. Phylogenetic continuity between Aborigines and lower animals has not been shown to exist and probably the greater part of this behaviour is culturally transmitted, since the behaviour ceases or changes radically when the culture breaks up, as it does among 'transitional' Aborigine groups. It is suggested that these analogies may still be meaningful rather than 'false'. That is, an environment with components in common with other organisms leads to the development of similar behaviour rather than some equally adaptive but different behaviour because of a genetic disposition to learn in this way. Equally there seems no escape from the evidence that a substantial cultural element exists.

SUMMARY

An account is given of stereotyped aggressive acts performed by Australian Western Desert Aborigines. These acts include stereotyped spearing, clubbing and magical procedures. The stereotyped form may be changed in various pathological states or inhibited by placatory gestures. This behaviour has been examined using ethological concepts and analogies between their behaviour and stereotypy formation, displacement activity and placation of aggression in animals have been described. The survival value of this behaviour for the individual and the group is discussed. A distinction is made between analogous and homologous behaviour, but a claim is made for the analogies described to be considered meaningful ones.

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Melancholic violence and cognitive dysfunction

BY CARL P. MALMQUIST*

In contrast to the surfeit of articles dealing with depression and self-directed aggression in the form of suicide, a relative neglect of the relationship between depression and homicidal aggression exists. This article analyses the nature of cognitive dysfunction in depressions, utilizing theoretical models and clinical material. For purposes of conciseness the discussion is confined to psychotic depressive disorders. Cognitive distortions, seen in the severely depressed, contribute in a direct and necessary manner to acts of violence. These cognitive distortions give a potential to act out aggression against others which can be conceptualized in terms of dispositional tendencies. Psychotically depressed individuals do not perceive many of the details of their behaviour due to the presence of cognitive delusional distortions. Nor are they cognitively able to appraise their acts from impairment in ego and superego functioning. Legal implications follow from these formulations because the rules of responsibility for criminal acts are customarily phrased as cognitive questions. One is judged by his appreciation of the knowledge of an act or its wrongness.

The closeness of self-aggression and aggression directed outwardly against others is witnessed in reports of occasional homicide-suicide combinations carried out by severely depressed people. Explanations are based on formulations of miscarried aggression, and this is so whether the explanation offered is based on a phenomenological, behavioural or psychodynamic approach. Prominent cognitive aberrations in psychotic depressions tend largely to be ignored, in contrast to cases of schizophrenia where a bizarre killing occurs. The following are discussed: (1) implications

of cognitive dysfunction in psychotic depressions from tendencies towards misinterpreting external and internal reality; (2) heightening of the potential for violence against one's self and others during such depressions; (3) cognitive deficits in depressives at the time of a violent episode; (4) an analysis of violence-proneness in the severely depressed based on dispositional tendencies; and (5) legal implications for such cases when the criterion for criminal responsibility is based on intact cognitive functioning.

COGNITION AND DEPRESSION

Two major conceptual difficulties are present in attempts to explicate cognition and depression: (1) the nature of cognitive dysfunction associated with depressions, and (2) gaps in our knowledge of developmental antecedents for depressions in which the specific emergence of cognitive deviancies could be appraised. Slowness or difficulty in thinking are referred to as consequences of a pre-existing depression. Nosological dichotomies between 'thinking' and 'affective' disorders then get interpreted as requiring these categories to remain mutually exclusive. An initial question is then the disturbances in thinking occurring in depressive disorders. Although the thinking disturbance may be primary or secondary, an initial step is the confirmation of such psychopathology. The matter is contingent upon the interpretation given certain clinical phenomena which most clinicians agree are present in depressions apart from differences between types of depressive diagnoses or syndromes. Finally, how does a disturbance in cognitive ego functioning in depressions operate and affect other ego functions? Specifically, what is the relation-

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ship of these dysfunctions to what appear to be senseless or wanton acts of destruction?

The second difficulty is related to insufficiencies in our developmental formulations. Lacking a model which permits us to detect and diagnose when cognitive aberrations emerge in children, we are unable to detect the cognitive prodromata of depressive-prone development. In fact, the behavioural and phenomenological aspects of childhood depressions are often ignored (Malmquist, 1971). Perhaps this avoidance has been a reaction against 19th-century descriptions of 'melancholic temperaments' or 'depressive constitutions', which were offered as explanations for whatever was called depressive. Our nosology also does not contain categories to describe depressive-proneness, such as a 'depressive personality'. Instead, references are made to other personality diagnoses, such as obsessive-compulsive personality, schizoid personality or cyclothymic personality. Attributes associated with a developing 'depressive personality' could include many of the hallmarks which later eventuate in psychotic thinking. *Anlage* would be present in ego development for a predisposition to react to painful situations or losses with depressive affect as a preferred method of coping. In addition, there would be the emergence of dispositional tendencies as to how a child begins to think differently about himself, other people, and the world, in response to painful situations.

Developmental aspects of ego maturation demonstrate the impact of early object relations on ego functions and the capacity to tolerate deprivation (Zetzel, 1965). A threat of loss mobilizes emergency emotions, such as fear and rage, in the depressive-prone. Parallel to this, depressive thinking emerges which expresses self-evaluations of worthlessness, guilt, and self-contempt. These illustrate an alteration in the way a person conceives of himself. A structural construct of a sadistic superego berating the ego requires cognitive accompaniments. Impaired capacity to tolerate depressive affect leads to changes in one's

view of the world and self. In contrast to the abandonment of awareness and reality-testing in schizophrenia, a rather desperate attempt to maintain contact with the world commences in the depressive. People are perceived as unresponsive to efforts at obtaining rewards. Misperceptions may be for anything previously expected to lead to rewards – be it virtuousness, accomplishments or idiosyncratic behaviours. A crucial step is the development of a cognitive diathesis so that lack of these rewards is assessed not as a circumstantial fault, but rather due to personal failings. Blaming the world may occur – especially in the neurotically depressed or those with paranoid trends – but assessing one's self at fault gains prominence. Instead of withdrawal and construction of a grandiose world, there is a constant overreaction to the existing world. It is as though the objective world cannot be fended off from its constant impingement. Instead of denying or repressing the objective world, there is an overdose of reality. Depressive thinking serves the function of painfully maintaining contact with a world that is construed as unrewarding rather than reconstructing a world in fantasy. Maintenance of a tie to objects, cognitively construed as necessary for survival, takes on masochistic themes.

Progressive ego and superego regression leads to impairment in reality-testing from a despairing view of the world that becomes unassailable. Rumination about worthlessness and hopelessness impairs the ego capacity to appraise itself. Given such a predicament, in time the superego can no longer make valid moral judgements as to how guilty or blameless one is. An individual then loses his capacity for differentiating truth from falsehood. Reality-testing and morality may well lose the semblance and substance of objectivity. Given such cognitive liabilities in a regressed ego state, the potential for an act of violence by drive regression is enhanced. If an individual not only feels, but thinks of himself as caught in a helpless situation, the potential to destroy himself or those with whom he has

'fused' is magnified. This is especially so for a homicidal act during a regressed state with cognitive distortion. Unfortunately for research purposes, the incidence of suicide or homicide is so low within any general population that prediction is perhaps impossible and explication of such rare acts is by clinical postdiction.

Beyond the usual descriptive signs and symptoms, criteria for psychotic depression vary. Predominance of severe dejection, self-depreciation and self-blame involve a colouring and contamination of the way an individual *thinks* about himself. This cognitive emphasis is essential since ultimately depression is the way an individual *thinks* about himself as well as how he *feels* about himself. If such cognitive developments follow or precede mood changes is difficult, if not impossible, to assess empirically. There is no compelling reason to place either prior to the other on the basis of observations or implications that can be drawn. Regressions in all three mental structures are seen in impaired object relations with accompanying withdrawal, preponderance of a hopeless internal reality, and fantasies – in contrast to 'reality-testing' guided by external or objective criteria. The degree of regression is fundamental since it influences the extent a person can accurately appraise himself. At a transition point, the capacity to revise concepts becomes relatively unassailable although it may fluctuate with intermittent psychotic depressive episodes over a lifetime. The hypercritical inner world of the depressed then predominates over the ability to perceive external reality and reason correctly about it.

When this state is reached, an abandonment of environmental attempts to restore self-esteem has been reached. Reassurance is *passé*. Acting out, or attempts to extract from those in the environment, fails to ward off cognitive depreciation. The patient is rather at the mercy of internalized judges, protectors, and accusers, and his 'convictions'. Guilt and hostility are present to a degree beyond neurotic states in that the threat to the psychotic ego

is that of a disintegration of the self. Since self and the world of external objects may not be perceived accurately or separately, there is a survival threat when an alteration occurs in either. This is not merely a conflict over expression of impulses connected with threats of abandonment, disapproval, or castration, but a threat to integrity on a psychological or physical plane (Frosch, 1970). With self-hatred in abundance for those on the depressive continuum, or in a category *sui generis* of psychotic depressiveness, derivatives such as experiential states of self-loathing or self-hate commence. It is illogical, and contrary to clinical evidence, to maintain that arousal of intense self-hatred, in settings where one's existence is at stake, does not contain an imminent threat to others and oneself. The conscious experience is that of an unforgivable sense of guilt which requires a parallel cognitive reconstruction to justify and give reality to the guilt.

Extremes of self-contempt give rise to delusional thought content which evolves and is used in the service of pseudo-rationality. Suicide or homicide is the ultimate solution in patients whose lack of self-approval has reached such an end point. Fortunately, the cyclical nature of depression phenomena, environmental alterations, or treatment, may prevent an outcome of violence towards oneself or others. If not, an extermination of the hated self, parts of the external world which have failed to relieve the helplessness, or fused objects, occurs.

COGNITIVE OPERATIONS

Although cognition is not new to psychology, cognitive psychiatry is a recent development (Arieti, 1965). Consideration has been given to such problems as thinking disturbances in schizophrenia, emphasized in the past work of psychiatrists such as Kraepelin (1921), Meyer (1951) and Kasanin (1944). Cognitive emphasis has sprung from extending the learning model of stimulus-response theory to include internalized constructs or mediators which have a 'mapping' function. Formation

of sentences and learning a language are seen as requiring complex and internal cognitive operations. Experiences are selected and processed, and what is chosen for processing from a variety of stimuli is part of a 'selective strategy'. Selection is an ascendancy of internalized representations extracted from the environment. The contrast between such a model and one which is stimulus-bound is striking. The 'internal' is reinstated as not only meaningful but necessary for description and explanation of behaviour while avoiding the old pitfalls of introspectionism. It could be argued that mental functioning presupposes cognitive structures, and perception would be one manner of comprehending stimuli. Motivation is then a product of perception or cognition (Prentice, 1961). Extensions of cognitive theory into impulse control, appraisal of decision-making alternatives, adaptive use of strategems and fashioning experiences by 'cognitive styles' are phenomena purveyed in ego psychology. These processes are also impaired in depressions.

Texts do not emphasize the cognitive components in depressions, with a few exceptions (Kraines, 1957; Beck, 1967). General characteristics of cognition will be noted prefatory to applications to the psychotically depressed. Cognitive factors do not negate the possibility of constitutional predisposition towards depression via biological variables which may be expressed via different cognitive modes and propensities. Freud early relied on a cognitive model in 'The Interpretation of Dreams' (1900). This was based on frustration of drive discharge inducing a state of hallucinatory wish fulfilment. The primary process was elaborated in dreams and in the dream work of wish-fulfilling thoughts. These processes can be viewed as disturbances in thinking on an unconscious level. Conscious thought processes operating outside a sense of time, with an absence of negatives, conditionals or qualifying conjunctives, and with an emphasis on allusion, analogy and symbolization, raise suspicions for a thinking disturbance – unless artistic or creative thinking is in

question. However, many altered states of consciousness, besides dreaming, show such cognitive processes.

Recent formulations have extended the secondary process model of thinking in developmental terms. A hierarchy of ego functions permits structuralized delay so that primary process forms of discharge thinking are restricted (Rapaport, 1951). Delay similarly permits concept elaboration. Instead of discharge, reasoning permits the solution of problems, weighing alternatives, and formation of concepts. Psychologically, this is determined by drive and conceptual components with coordinates between contiguous and logical implications. Rational thinking requires empirical laws of thought and a set of normative rules. Whether faulty thinking processes are primarily due to an abandonment of logical rules is an ancient question. There is evidence that it is just as likely to be in the context of inappropriate concepts employed in reasoning (Henle, 1962). This corresponds to clinical impressions of distortion in content as primary with logical deductions that follow appearing valid because the content remains unquestioned. Delusional thinking is a prime example.

Thinking in the service of problem-solving with a minimum of affective interference and a maximum of rigorous logic is contrasted with thinking which has a predominance of affective components. The latter secondarily acts on a pre-existing fallacious content, but takes precedence over other problem-solving efforts. Delusions or obsessions are not only fallacious initially, but gain ascendancy in cognitive operations from other tangential material becoming entangled in their web. Delusions are more than an abnormal belief in a vacuum since they carry social implications. Reasoning processes are helpless to refute such beliefs since the beliefs are incorrigible. If the content is not strikingly bizarre, as in schizophrenia, laymen and clinicians pass off the delusional comments of the depressed.

Depressive delusions have recurrent themes. These involve inadequacy, inferiority, loneli-

ness, emptiness, impoverishment, self-criticism, concern over trifles, and alternations between wishes to escape overwhelming demands. One of the most pervasive themes is that of self-degradation varying from verbalizations of being 'no good' or a failure, to being the worst sinner on earth. Dynamically, this is attributed to attacks of a punitive superego whose extremity is due to its infantile origins with great ambivalence towards a loved object. Some clinicians are hesitant to ascribe self-deprecations to disturbances in cognitive processes. They hold these 'beliefs' are not 'real' delusions. The problem with such restrictions is that delusions tend to get confined to one type of thinking disturbance, such as paranoid mentation. An additional argument against such restrictions is that delusional thinking becomes pathognomonic for one nosological entity. This itself is a *petitio principii* fallacy, i.e. one holds that if a cognitive disturbance is present, the condition must be of a certain type, such as schizophrenia. This formulation is logically and psychiatrically too restrictive. Adequate observational data exist to support a position that those with psychotic depressions are not merely verbalizing self-depreciatory comments without believing them.

Is there a qualitative difference between delusions of a nihilistic type ('A terrible catastrophe is imminent') or a somatic type ('My stomach is rotting') seen in psychotic depressions? The latter are less challengeable as a thinking disturbance in contrast to other equally unassailable thoughts about one's worth. Clinical investigation is able to demonstrate a continuum to nihilistic or somatic delusions. An initial aura of 'gloom and doom' may progress to a conviction of nihilistic hopelessness. Similarly, periods of hypochondriasis, which wax and wane in a depressive, may eventuate in a conviction of physical deterioration. However, a complexity is present in appraising one's worth not present in other types of thinking disturbances. Evidence for the delusional nature of somatic delusions based on medical and laboratory data to the

contrary can be cited. With paranoid mentation, an appeal to environmental data may assist in appraising suspicions. But the valuational process of appraising oneself by independent criteria is fraught with problems. Perhaps this is why some object to applying standards of delusionality to beliefs about oneself. If a person believes he is a personal failure – a worthless human not fit to continue living – how is one to confirm or disconfirm this? The best that could be done would be to look for external referents to see if such self-appraisals are valid. Since most individuals suffer shortcomings, the minor carplings of the depressive are usually ignored. In fact they are taken as a sign of moral praiseworthiness. This may be one reason why these signs in a depressive are so often overlooked. When the superego continues its self-devaluation to the point of opining that a person is unsalvageable or should not continue living, we are more willing to question cognitive intactness – just so he 'really means it'. Even here, narcissism mixed with self-pitying verbalizations leads to ignoring them as merely self-pity. The intrapsychic nature of delusions of self-depreciation confuses attempts at applying external referents to the question if the belief is 'true' or 'false' rather than believed. Yet clinically it is the sense of personal conviction that gives a disposition to violence.

COGNITIVE FALLACIES IN PSYCHOTIC DEPRESSIVES

Predisposition to depressions has a vulnerability to use of logical fallacies. Developmentally, a hypercritical superego threatens punishment for minor failures – interfering with the development of reasoning processes in the ego. Hypercriticalness leads to impairment in the ability to anticipate if one's activities will be worthwhile. Expectations of failure permit inferences to confirm pre-existing anticipations of inadequacy. Consequently, attempts to tell a person with a psychotic depression to 'snap out of it' or 'start thinking right' have only transitory

effects. Reassurances that physical pathology is absent at best give a cognitive appreciation that appraisal of one's body may be inaccurate. Consider a severely depressed patient who has a daily bowel movement, but continues to believe his intestines have turned to concrete. This type of thinking represents a transformation of the psychologic to the experiential in terms of everything being slowed, heavy, and deteriorating. It is manifested in a conviction that one's bowels and the world – as well as one's future – are in a state of chronic obstruction.

This raises the question of formal disturbances in cognitive processes in contrast to content. Beck (1964, 1967) has divided them into logical, stylistic, and semantic types. Clinical material from 'intact depressives' illustrates the genesis of such formal defects. 'Arbitrary interference' fosters false inferences of a self-depreciatory nature. A depressed individual leaves his name with a prospective employer and does not receive a call. He infers this must be due to his inadequacies without knowing any other relevant material and without making further inquiry. A depressed young female, offered a teaching job on a supervisory level – viewed as a promotion by her colleagues – continues to feel that if she had performed better, she would have been re-offered the routine teaching position formerly held. The proffered position was viewed by her as a result of personal shortcomings. A process of 'selective abstraction' operates to give isolated details major significance. A depressed professor, finding his productivity impaired, interprets a question from a colleague, 'How is your work going' as referring to his failure to produce. In contrast to paranoid mentation, the question is viewed as appropriate since his failure to produce is believed to require chastisement. Clinicians, as well as patients, easily view this as 'reasonable'. Work failure may be viewed as a cause of subsequent problems, and seen as a personal moral failing. A job trainee reads a report referring to his assets which place him in the most competent group. One comment is

selected: that he attend a management seminar to make him more competent. The last comment is the one extracted as relevant and seized upon to the exclusion of the remainder of the glowing report.

A fundamental challenge is that thinking disturbances are present in almost everyone at times. Therefore they should not be regarded as pathological. Puzzling emotional states, as well as thinking 'disturbances', occupy everyone periodically. The issue is when such deviations should be assessed as pathological. This is merely another way of phrasing the unresolved question if pathology is merely a quantitative extension of normal deviancy or qualitatively different? If quantitative measures are available, it involves a decision as to where a cutting score should be made. When a disturbance in cognitive processes persists to the extent of not being logically assailable, it is seen as pathological. Which diagnosis to apply should not be based on thinking disturbances seen as pathognomonic of only one area of psychopathology.

Knowledge of cognitive structures and their function can be applied to cognitive distortions in depressions. Concept formation, ability to solve problems of varying complexity, internalized 'mapping' used for thinking – all bear on the nature of reasoning. Developmental aspects of cognition are relevant since regressive processes reinvoke types of thinking used at preceding developmental levels. Ego regression in cognitive functions to a pre-formal type of thinking is parallel to superego and id regressions in severe depressions. Thus the muteness or semimuteness of a depressed individual may not be sufficiently explained by a psychodynamic model without consideration of cognitive correlates which impair language usage and its logical application. This may be one factor when patients with psychotic depression, and previously established high intelligence, think concretely and find their discriminatory capacity defective. When affect and fantasies about one's worthiness, loneliness and lack of gratification dominate, language is used in the service of

defective axioms about the self. A distorted use of abstract reasoning results in thinking more characteristic of the child from three to five years. Language restricted to negation, autism, or simple referential language is reflective of even earlier developmental periods.

Formal operations of inductive and deductive reasoning may be impaired in depression and generalization limited to analogies from one characteristic to another. Such fallacies occur as, 'I am a guilty sinner because of transgression X, and therefore am a guilty sinner in other respects as well'. Again, this is a type of thinking observed in the pre-oedipal child. The heightening of narcissism in depressions, manifested as a withdrawal from object contacts and preoccupation with one's suffering, has an egocentrism of thought where the world and its events are interpreted as phenomena revolving about the patient. What is clinically a self-centred brooding has a parallel impairment in being unable to predict the consequences of certain acts on others or to comprehend their response. An insensitivity to others' feelings or viewpoints results due to the narcissistic preoccupation of the depressed. Cognitive processes operate in the realm of content as well as manipulation of content by inferential processes. Hence, content distortion can occur ('I am a worthless person') as well as in the application of cognitive material. Impulse dyscontrol is a possibility since cognitive content is not isolated from drive levels, fantasies, superego dictates or environmental input. There is also the problem of relating cognitive function to choice of defence. It is in the area of distortions in cognitive content regarding one's self-worth and worth to others that depressive delusions reside.

Consistency in cognitive appraisals suggests enduring mental structures. Within these consistencies individual differences illustrate variations in everyday performance in cognitive functions and styles. Given sufficient knowledge, or subtle enough measures, to detect when cognitive malfunctioning develops, knowledge of delusional self-appraisals can be

made and predictions as to the probability of consequent actions. In the absence of such assessments reliance must be placed on clinical judgement with the help of less exact aids, such as inferences from psychological tests or from recognizable neurological deviations. Unfortunately, these evaluations are often postdictive, rather than predictive, such as commencing after a violent eruption. For patients with depressive character structures, notation of an 'impairment or slowness in thinking' is far too gross an index to use for prognostic statements. The greater the pre-existing vulnerability to depressive thought processes, the greater the degree which content associated with a depression is unquestioningly accepted as valid. At some point along a continuum, an attribution of delusional thinking is made, but this does not usually occur short of a frank psychotic episode. Even then many psychotic depressive states are overlooked. It is the dilemma associated with recognizing that pervasive mood disturbances may harbour cognitive aberrations. A dramatic outburst of violence provides a realization that the patient 'really believed it'. The potential for actualizing some of these dispositions exists long before any type of concrete action results, and typically fluctuates without the point of no return being reached for most patients.

CLINICAL APPLICATIONS

Clinical work indicates a degree of hatred towards ambivalently loved objects so that a regression to psychotic functioning is conducive to a blurring of boundaries between subject and object. Since any loved object poses a threat to narcissism by virtue of one needing it, a greater probability for its destruction in a regressed state occurs. Elementary distinctions between 'I' and 'Thou' then break down in fantasy and cognitively. While aggression can be directed against objects which are fused in fantasy and confused with the self, there may also be a discharge of aggression against external objects. Ultimate impairment in reality-testing is seen in homi-

cide-suicide combinations which are most prevalent in the intimacies of marital or semi-marital relationships, such as with wives, girl-friends, lovers or children. This is most striking when a violent act results from bizarre thinking leading the depressed to believe he is accomplishing an act of noble proportions by sparing others from living a continued existence with him. These misplaced 'mercy killings' are regarded as acts of altruism (Harder, 1967). A brooding self-hate with a regression in object boundaries results in a homicide which has a facsimile of being a premeditated act of cold-blooded murder. The same type of act, based on similar cognitive operations, resulting in the death of those other than infants, raises scepticism with regard to it being the product of a 'deranged mind'.

CASE ILLUSTRATIONS

(1) A single, deeply religious female of 27 years became progressively despondent after her mother's death four years earlier. Although able to continue routine clerical work with no detectable impairment, those close to her noted changes such as difficulty in experiencing humour. She could laugh with a forced quality in response to intellectual cues when laughter should occur. For several years preceding the death, she and her mother had lived alone after her father's death. Opportunities to marry before and after her mother's death had been refused. No tears were ever shed on receiving notice of her mother's death, or subsequently. Attempts to work in different geographical settings had not produced any change in her status.

An effort to 'restore feelings' led to frequenting dance and entertainment establishments with girl friends and led to meeting male acquaintances. Many expressed interest and one asked her, in response to a sexual rebuff by the patient, when she would join the 'big leagues' and act like a grown-up? This led her to refuse all his future calls, which ceased in a month. In the interval depressive symptoms became prominent. Her previously outstanding secretarial performance showed imperfections, partially due to difficulties in attention, but also from restless sleep with intermittent waking and dream content about her mother. A conviction of having sexually been 'too free' became a preoccupation even though aware of

having done nothing beyond kissing. Feelings of being 'no good' on recalling harsh words and condemnations she had made towards other people in her life became unassailable.

Without being clear on details of when and where the plan was devised, she purchased a gun and contemplated suicide. After spending days brooding, she was unable to convince herself she would avoid hell by suicide. Instead she contacted the ex-boy-friend, whom she had not seen for six months, and arranged a date, telling him she was ready to join the 'big leagues'. She arranged to meet him at his apartment and came equipped with the gun in her purse. From then until firing her revolver, there was amnesia. The victim's recollection was that the patient was drastically different as she entered his apartment from his earlier recollections; she was seductive and had make-up 'plastered on'. When she suggested that they neck, he experienced a quality of 'eeriness' - 'like it would have been making-out with a corpse'. Instead, he suggested they have a drink and walked to the other side of the room. Several shots were emptied into his back.

Later reconstruction was able to reveal that her fantasy was to be 'dishonoured' by the man, giving her a justification for killing herself. When she sensed he might not oblige, a panic arose since her justification for killing herself after being dishonoured would be gone. She recalled a mounting anxiety, culminating in the shooting, followed by a quietness as she called the police from his apartment.

Questions may be raised about other types of thought content in depressions. A conviction of guilt for some transgression, even of minor magnitude, may lead not only to verbalizations about guilt, but literally to acts which seek out a sought-for punishment and expiation. If the depressive does not really believe his self-deprecations, one is left in the predicament of viewing his proclamations as charades, and resultant violent acts as those of wanton cruelty and depravity. Clinical material would support a view of a firm conviction of one's guilt in patients with such depressions.

In moderate depressions the depreciatory self-concept and guilt are not as striking. They are interlaced with occasional optimistic and constructive comments with the dangers of an end-stage of nihilism about the world and one's worth rarely being appreciated. Fortunately, accidental favourable changes in the environment or treat-

ment may intervene in cases to abort destructive acts. Associated with this is the denial by observers who do not wish to register the full impact of what they perceive. Cognitively, the irrationality may be so subtle and seemingly exaggerated that laymen as well as clinicians ignore it.

(2) A 65-year-old man with an agitated depression of several years' standing decided he would stop his torment about failures to do routine tasks. These tasks were of a minor nature, such as household repairs, going to the bank for a registry of interest on a savings account, which his wife and himself had been prompting. Upon waking at 5 a.m. he went directly to a cabinet, removed a gun which had been there for years, and shot his wife of 35 years' duration who never awakened. This act appeared to be the elimination of a tormenter in the form of an externalized self in which the differentiation between the hypercritical superego of the self and that of his wife was lost during the course of a psychotic regression with reality-testing lost. Although consciously the act was totally inexplicable to him, his reality-testing was such that he immediately called the police. He had no recollection of any plan or conscious desire to destroy his wife, yet could recall a restless sleep followed by waking and directly going to the cabinet and shooting. A conviction of homicide was obtained.

IMPLICATIONS FOR LEGAL RESPONSIBILITY

Applying this analysis to the cognitive defects in the severely depressed permits causal inferences to be drawn from a series of predisposing factors. A combination of beliefs, statements, and feelings about oneself gives the person a disposition to proceed as though his personally distorted cognitive referents are literally true. There need not be a commitment to a proposition that certain kinds of cognitions must take precedence over depressive affect – the primacy of cognition over affection. However, there is an implication that some of the necessary conditions in a psychotic depression are the distortion in reasoning and conceptual capacities which inhere in depressions. This may lead to behaviours which are 'irrational' and may be 'antisocial'. The cognitive component of cyclothymia holds not only in the affective realm but for cognitive distortions of over-

inclusive or underinclusive thinking and categorizations about one's self and the world. The closeness of alternative solutions in psychotic depressions between destroying one's self, or destroying the world and objects in it, has been discussed. The potential for a final solution based on distorted cognitive referents always looms imminent.

Attempts to delineate cognitive dysfunction have a sociological significance beyond purely psychological interest. Legal rules and statutes governing responsibility for criminal behaviour are usually framed in terms of cognitive functioning. The typical question is whether the mental illness or defect has an accompanying cognitive defect, such that the capacity to 'know' is disturbed? If so, it permits a conclusion that an individual would not have known the nature of his criminal acts, or that his reasoning was so impaired as not to function in appraising the rightness or wrongness of an act at a certain time. These are merely paraphrases of the McNaghten rules. If thinking disturbances are not confined to schizophrenia, but must include psychotic depressions, direct questions about the criminal culpability of psychotically depressed patients are germane. In fact, cognitive disturbances are not confined to any one nosological grouping. They are witnessed in many types of psychopathology, such as neurotic obsessional thinking or kleptomania. A theoretical explanation of such lapses requires psychodynamic and cognitive models. Such routine psychological processes as knowing, appraising, intending, and acting, raise further complex philosophical and legal issues.

The ubiquitousness of the potentiality for suicide in severely depressed patients is unquestioned. Achieving this end-point of self-destructiveness is still a statistically rare event from amongst the depressed. More common are varieties of self-injurious behaviour. Extreme forms of indulgence, denial, and conspicuous forms of acting-out are observed. Examples are the failure of an executive with an annual income of \$50,000 to file an income tax return, blatant forms of pilfering, high-risk activities, as well as overt antisocial

behaviour. Not so unquestioned yet is the nature of the potentiality for homicidal aggression in severely depressed patients. Acts of homicidal aggression against spouses and children (infanticides) have been noted, which appear inexplicable even to many professionals, since the individuals do not appear blatantly psychotic or psychopathic, nor do they have the usual signs and symptoms of schizophrenia. When examined weeks or months following a violent episode, they may not appear profoundly depressed. For some this is analogous to the lifting of a depression subsequent to a failed suicide attempt. Psychiatrists are aware of these dilemmas, but the issue is raised most cogently when the behaviour is evaluated by the rules of personal responsibility applicable in our legal system. Since the legal framework operates overwhelmingly within the realm of cognition and defects of reason for negating criminal intent, there are many implications for a depressed individual whose dispositions give him a special vulnerability towards a violent or antisocial act. The appraisal offered is not to reject notions of responsibility based on cognitive questions, but rather to stress the cognitive

disturbances which may be present in psychotic depressions and elicitable on examination once a theoretical framework is available.

SUMMARY

An analysis of theoretical questions about the nature of cognitive defects accompanying psychotic depressive disorders is given. Such defects permit the individual to operate with delusions about himself which are often ignored. The vulnerability of the depressive character to regress in several spheres permits acts of violence buttressed by cognitive self-referents. Failure to appreciate these potentials permits outbursts, which are puzzling in view of the seeming lack of blatant bizarreness in the thought processes. Rather, there are tinges of admirable humility and self-abnegation present. Although questions of responsibility of the depressed are raised much less frequently in courtrooms than other diagnoses, it is contended that such patients may not have comprehended the nature of their acts at the time of their occurrence due to cognitive delusional distortions. Nor would they at the time have appreciated its 'wrongfulness' to society or in terms of their own superego system from it being a logical and congruent outcome based on a set of dispositions toward such behaviour.

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'Psychological' constructs and delusions of persecution and 'non-integration' in schizophrenia

By F. M. McPHERSON,* FELICITY BUCKLEY* AND JOAN DRAFFAN*

This is one of a series of studies in which the use made by psychiatric patients of 'psychological' constructs (concepts) is related to the presence of clinical signs and symptoms, in this study to the presence of certain types of delusion in schizophrenic patients.

When describing and differentiating among people in photographs, some schizophrenics make very little use of constructs (Kelly, 1955) referring to 'psychological' attributes, i.e. those relating to the personality characteristics, emotional state and abilities of the people. These schizophrenics tend to exhibit the clinical signs of 'flattening of affect' (Dixon, 1968; McPherson *et al.*, 1970a, b; Rush, 1970). They also tend to show disordered performance on the Bannister & Fransella (1966) measure of thought-process disorder, which involves the ranking of photographs of people according to 'psychological' constructs, such as 'kind' and 'honest' (McPherson *et al.*, 1971). In contrast, Dixon (1968) found no association between affective flattening and the use made of 'non-psychological' constructs, such as those referring to the physical features, or activities, of the people in the photographs; this was confirmed by McPherson *et al.* (1970a, b) and by Rush (1970). Also, thought-process disordered schizophrenics show less disorder on the Bannister-Fransella task when ranking constructs referring to physical attributes than when using 'psychological' constructs (Bannister & Salmon, 1966; McPherson & Buckley, 1970).

McPherson *et al.* (1971) have suggested that some schizophrenic patients lack a coherent and stable construct subsystem (Bannister & Salmon, 1966; McPherson & Buckley, 1970).

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nister & Salmon, 1966) for the description and prediction of psychological events. This shows itself in their failure to use 'psychological' constructs spontaneously, as in Dixon's (1968) photograph-description task. When they are *required* to use such constructs, as in the Bannister-Fransella task, they can use them only in an uncorrelated and inconsistent manner. If such an abnormality exists in the use of concepts, it would seem unlikely to be related only to affective flattening and thought-process disorder; other schizophrenic signs and symptoms, such as delusions, would probably also be affected.

Foulds (1965) distinguished *persecutory* delusions from delusions of '*non-integration*' or '*disintegration*'. Persecutory delusions are those in which the patient believes he is being plotted against or harmed by people around him. Delusions of '*non-integration*' are those which involve: disruption of the patient's body-image, with him believing that something is unusual about his body; feelings of ineffectiveness, with the patient wondering who he 'really is'; and hallucinations, which indicate a blurring of the boundary between self and other.

A patient who believes that he is being persecuted is making various assumptions about the attitudes and motives of people around him and is thus construing in 'psychological' terms, however abnormal the specific constructs may be. It seems unlikely that paranoid delusions could be sustained in the absence of a reasonably systematic and stable set of 'psychological' constructs. Delusions of '*non-integration*', on the other hand, seem to imply a disturbance of a patient's *awareness of himself as agent* and a difficulty in defining himself psychologically,

of the sort that might be expected if he had no stable system for describing and explaining 'psychological' attributes.

According to this view, patients whose 'psychological' construct subsystem is coherent and stable in structure (though it may be bizarre in content) would be more likely to exhibit delusions of persecution than delusions of 'non-integration'; however, the latter should be more common in patients lacking such a system. McPherson (1969) confirmed this prediction in samples of 24 acute and 24 chronic schizophrenics, using Bannister-Fransella intensity and consistency scores as measures of the extent to which a patient has a coherent, stable 'psychological' subsystem. The present study attempts to confirm the prediction using a different measure - the frequency with which a patient spontaneously generates 'psychological' constructs when describing people, in the way described by Dixon (1968) and McPherson *et al.* (1970a, b). Patients who make little spontaneous use of 'psychological' constructs may be expected to admit to delusions of 'non-integration' rather than of persecution; those who use 'psychological' constructs as frequently as normals may be expected to admit to a preponderance of persecutory delusions.

METHOD

Subjects

Fifty-five schizophrenic patients were tested. They comprised all the patients in the admission wards of a psychiatric hospital over a one-year period who satisfied the following criteria: (1) they had an undisputed diagnosis of schizophrenia; (2) they had not previously been psychologically tested; (3) in the opinion of their psychiatrist, they were showing active psychotic signs or symptoms (not necessarily delusions) at time of testing.

Twenty-seven of the 55 patients had been clinically diagnosed as paranoid schizophrenics; of these, 13 were acute and 14 were chronic (the cutting point being two years from first admission to hospital, or diagnosis of schizophrenia). Of the 28 with non-paranoid schizophrenia (hebe-

phrenia, catatonia or simple schizophrenia), 15 were acute and 13 were chronic.

Measures

1. *Use of 'psychological' constructs.* This was assessed in the way described by Dixon (1968) and McPherson *et al.* (1970a, b). The patient described differences between the people in five pairs of photographs, and a content analysis of his tape-recorded responses was carried out to discover the percentage of 'psychological' to other types of construct which he used. The content analysis was done 'blind', and independently, by two scorers. Inter-scorer agreement was high. Thirty of the content analyses were carried out by scorers 1 and 2; the Spearman rho between the rankings of the 30, based on the percentage of 'psychological' to 'non-psychological' constructs obtained by each scorer, was $+0.95$ ($P < 0.0005$). Twenty-five content analyses were done by scorers 1 and 3; between this pair, $r_s = +0.93$ ($P < 0.0005$). Where scorers disagreed, the mean of the two percentages was used.

McPherson *et al.* (1970b) found that two-thirds of a group of affectively flattened schizophrenics used 11.9 per cent or fewer 'psychological' constructs, whereas every member of a group of normals used 12.0 per cent or more. This cut-off score was used in the present study.

2. *Delusions.* Next, the Delusion Scale of the SSI (Foulds & Hope, 1969) was administered. Five items refer to delusions of persecution: D3, 4, 6, 7 and 10; four refer to 'non-integrated' delusions: F2, 3, 7 and 10. The relative frequency of persecutory to 'non-integrated' delusions was assessed by subtracting the number of 'non-integrated' delusions to which the patient admitted, from the number of persecutory items affirmed. High positive scores therefore indicated a predominance of persecutory delusions, and high negative scores a predominance of 'non-integrated' delusions.

RESULTS

Twenty-four patients had 'psychological' construct scores of 11.9 per cent or less. These 24 did not differ significantly from the 31 who had scores of 12.0 per cent or more in: age, vocabulary scores (Mill Hill Synonyms),

DISCUSSION

the proportion of paranoids to non-paranoids, or in the proportion of males to females. However, there were significantly fewer acute than chronic patients among those with scores of 11.9 per cent or less ($\chi^2 = 6.20$; d.f. = 1; $P < 0.02$, two-tailed test).

The delusion scores of the 28 acutes and 27 chronics were analysed separately. The 10 acutes who had 'psychological' construct scores of 11.9 per cent or less had a mean delusion score of -1.03 , indicating a preponderance of 'non-integrated' delusions; the remaining 18 acutes had a mean delusion score of $+0.14$, indicating a slight preponderance of persecutory delusions. The difference between the groups was statistically significant (Mann-Whitney U test: $z = 2.48$, $P < 0.01$, two-tailed test). The 14 chronics who had used 11.9 per cent or fewer 'psychological' constructs had a mean delusion score of -0.64 whereas the 13 remaining chronics had delusion scores of $+1.31$. This difference was also statistically significant ($z = 3.74$; $P < 0.0002$, two-tailed test).

This tendency for those patients who used fewer 'psychological' constructs spontaneously to have 'non-integrated' rather than persecutory delusions existed also within the paranoid and non-paranoid groups. The 10 paranoids with scores of 11.9 per cent and less had a mean delusion score of -0.74 compared with $+1.11$ for the other 17 paranoids ($z = 2.77$; $P < 0.02$, two-tailed test). Fourteen non-paranoids had 'psychological' construct scores of 11.9 per cent and less, and 14 of 12.0 per cent and more; the mean delusion scores were -0.79 and 0.00 respectively ($z = 2.82$; $P < 0.004$, two-tailed test).

The relation between the use of 'psychological' constructs and delusions can be expressed in another way. Of 13 patients who admitted only to 'non-integrated' delusions, 10 had 'psychological' construct scores of 11.9 per cent or less; all five patients who affirmed only persecutory items had scores of 12.0 per cent and over (Fisher exact probability test: $P < 0.05$, two-tailed test).

The results were clearly in line with prediction. Those schizophrenics who made relatively little use of 'psychological' constructs when describing people in photographs tended to admit to delusions of 'non-integration' rather than to delusions of persecution. Those schizophrenics who used 'psychological' constructs as frequently as normals tended to admit to a greater proportion of persecutory delusions. McPherson (1969) showed that the admitted presence of 'non-integrated', as opposed to persecutory, delusions was also associated with disordered performance on the Bannister-Fransella test.

Foulds (1965), discussing personality and personal (i.e. psychiatric) illness, suggests that it is useful to think of 'a continuum of increasing degrees of failure to maintain or establish mutual personal relationships, from psychopathy, through neurosis and integrated psychosis, to non-integrated psychosis' (p. 307). The integrated psychoses are depression, mania and paranoia. Only schizophrenics, although not all schizophrenics, comprise the 'non-integrated' group, which is defined clinically by the presence of thought-process disorder, inappropriate affect, e.g. flattening, and those delusions and hallucinations which involve a disturbance of the patient's awareness of himself as agent.

Foulds argues that these three clinical signs are secondary to a disorder of interpersonal relationships, which he describes as 'withdrawal without the intention of, or motivation for, returning to action, particularly to communication with others' (p. 307) and the 'lack (of) the intention or motive to enter into mutual personal relationships' (p. 312).

The ability of someone to enter into, and sustain, such relationships must clearly depend in part upon his being able to discriminate, evaluate and make predictions about the feelings, motives and attitudes of himself and others: in other words, he must possess a stable system for construing 'psychological' events. McPherson *et al.* (1971) have suggested that the infrequent use of 'psychological'

constructs, as on Dixon's task, and their use in an uncorrelated and inconsistent manner, as on the Bannister-Fransella test, both indicate the absence, in a patient, of a stable system of this sort. It is interesting therefore that all three of the clinical signs which, according to Foulds, characterize 'non-integrated psychoses' have been found to be associated with abnormal performance on either the Bannister-Fransella or Dixon tasks, i.e. thought-process disorder by Bannister (1960, 1962), Bannister & Fransella (1966) and Foulds *et al.* (1967); affective flattening by Dixon (1968), McPherson *et al.* (1970*a, b*), and Rush (1970); and delusions of 'non-integration', by McPherson (1969) and by the present study.

This series of studies therefore suggests that a relationship might exist among disorders at the clinical, interpersonal and cognitive levels, i.e. among thought-process disorder, affective flattening and certain delusions; withdrawal from mutual personal

relationships; and the absence of a stable and coherent system of 'psychological' constructs. This possible relationship will be considered more fully in a subsequent article.

SUMMARY

Schizophrenic patients who fail to use 'psychological' constructs when describing photographs of people tend to have delusions of 'non-integration' rather than delusions of persecution. The reverse is true of those schizophrenics who make normal use of 'psychological' constructs. The study is one of a series which together suggest a relationship between certain clinical signs, social withdrawal, and the use of personal constructs.

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MICHAEL BALINT

Photograph: Lotte Meitner-Graf

(Facing p. 281)

Obituary

MICHAEL BALINT

When he died at the age of 74 on the last day of 1970 Michael Balint was at the height of his working powers. He held major offices, as current President of the British Psycho-Analytical Society, editor of the *Mind and Medicine Monographs*, and Visiting Professor of Psychiatry at the University of Cincinnati. He was in active psychoanalytic practice, and training and researching with medical students, psychoanalysts and general practitioners. He was planning yet another teaching trip both to the United States and to Switzerland, and was at work on a new book concerned with psychoanalysis.

He was held in high renown in the world of psychoanalysis, while among medical psychologists none in his life-time was so eminent. For nearly half a century he had poured out contributions to the literature of psychoanalysis and medical psychology – seven books and well over 100 papers, some translated into several languages. His professional life had been lived eagerly and vigorously, and he had enjoyed and enriched his two professions of medicine and psychoanalysis.

He was born in Budapest, the son of a Jewish general practitioner. His brilliance showed early and at 15 he was coaching his school-fellows. His life-long love of classics, people and language (he spoke French and German as well as Hungarian and English) began at school, but his earliest ambition – to be an engineer – sprang from an equal delight in the exact sciences of physics and mathematics. He began the study of medicine in 1914, but soon postponed it for war service until 1916, when he was wounded and demobilized. Then he qualified as a doctor in 1920 and married in 1921. Because of the anti-semitism of the Horthy regime he left Budapest for Berlin that year and worked as a research chemist and biologist. In Berlin

he and his wife began to train as psychoanalysts, but Balint's twin interests in people and in scientific exactitude were already clear; at the very time he was treating his first psychoanalytic patients he became a Ph.D. in biochemistry.

In 1924 he returned to Budapest and completed with Ferenczi his own psychoanalysis, begun in Berlin with Sachs. He owed openly to Ferenczi a life-long imaginative interest in doctor-patient relations and early object relations, and to pure science he owed his discontent with inexact observation and his determination to distinguish observable fact, subjective fantasy and theory.

In Budapest he practised and taught students of psychoanalysis, directed the Budapest Psycho-Analytic Clinic and began seminars for general practitioners, but as the years passed racial intolerance grew in Hungary, and again in 1939 he emigrated, this time to Britain. He began work as a psychoanalyst in Manchester, took a British medical qualification and became an M.Sc. in psychology with a thesis on early infancy. At this time his wife Alice died, leaving him with their son John, now professor of medicine at Albany Medical School. He became consultant to the Northern Royal Hospital, directed two child guidance clinics in Lancashire, and remarried.

After the war he moved to London, worked as a psychoanalyst and became consultant to the Tavistock Clinic. Following a divorce from his second wife, Edna, he married Enid, and with her began his famous research-cum-training seminars for general practitioners. In 1950 he was Scientific Secretary to the British Psycho-Analytical Society and a member of Council, and during the 1950s was an active member of the Medical Section of the British Psychological Society, being in

1955-6 its chairman and a member of the Council of the British Psychological Society. In the years that followed he worked vigorously and happily at his two interests, psychoanalysis and medical psychology.

His many psychoanalytic writings cover a wide spread of interest from aesthetics to criminology, from early infancy to old age, and are a memorial to his determined questing and his unceasing curiosity about the meaning of human experience. They show him as a master of his craft, concerned to wed skill and science. He had an abiding interest in the way clinical technique, clinical observation and theory reciprocally influence one another. His interest in early ego states and early object-relations never ceased, and he treasured the clinical situation as their place of revelation. It was the psychoanalysts' sensitivity or insensitivity of response that decided their clinical fate, and so he sought that psychoanalysts should be highly informed but free from theoretical certainty, innocent and wide-eyed in their work with patients, and thoughtful about non-verbal mental influences. He was therefore much sought after as a stimulating undidactic supervisor who could help and allow the student to develop his own gifts.

In the field of medical psychology he undertook a major creative synthesis between group dynamics and the training relationship as an object-relation, developing and testing his ideas in practice and so producing the 'Balint Method' of training seminars, in which the trainees are not taught but are required to think and to become personal researchers about doctor-patient relations. He and they showed how these relations decisively affect illnesses and the outcomes of treatment. This novel contribution of psychoanalysis to pedagogics was developed with workers in the Family Discussion Bureau, which he and Enid founded, with doctors from the Family Planning Association (whose present 17 seminars are founded on his methods), and above all with general

practitioners. After some preliminary papers on the group dynamics of training and on the doctor-patient relation, he published in 1957 his historic book *The Doctor, His Patient and the Illness*. It had an immediate effect on general practitioners all over the world, for it offered them new hope and challenge and, with its emphasis on 'whole-person medicine', changed for all time the very perspectives of general practice. Within a few years doctors in Britain and in various other parts of the world were meeting together to pursue research-cum-training seminars by the methods he described. First the Dutch and Americans, and then the French, and later others made contact with Balint and required him to meet their trainers in regular international conferences. They sought him to conduct seminars in their own countries, and began to publish books which recorded their own new findings, about illnesses and the techniques of general practice which their new insights allowed. His other works in medical psychology, his innovating seminars in brief therapy, his studies with co-workers on the effects of training, his book with Enid on psychotherapeutic techniques and his many addresses and published papers, were illumined by his familiarity with the unconscious transactions between people in various settings and situations, and are a model of applied psychoanalysis.

Michael Balint experienced little of the common conflict between thinking and feeling, for he delighted in both; creative thoughtfulness *about* feelings - his own and others' - was his life. He was that rare creature - a scholarly sensitive man of action. His delight in others, his capacity to give and earn love, his enjoyment of vigorous argument, and his gentleness with people, together with the high skills that gave him such safety in mental adventure made him an exhilarating and lovable friend. Medical psychologists all over the world are now the poorer, and medical psychology has lost its staunchest worker.

T. F. MAIN

Short Book Notices

The Psychology of Perception. By WILLIAM N. DEMBER. London: Holt, Rinehart & Winston. 1969. Pp. xi+402. £3.00.

Professor Dember's special concern is with problems of measurement, visual psychophysics and the effects of learning on perception, as well as with autistic influence. In this book he presents much of what he has learned about exploratory behaviour from his own work and that of others. He expresses his belief that the current view of an organism as an active seeker of information will lead to some of the most exciting developments in contemporary psychology. The author puts primary emphasis on data acquisition and interpretation rather than on broad theories of perception, but continually stresses the relation between theory and data.

Third Conference on the Fundamentals of Psychology: Various Approaches to the Study of Perception. (Annals of the New York Academy of Sciences. Volume 169, Article 3, Pp. 595-738.) Edited by ERNEST HARMS and MARGARET E. TRESSELT. New York: New York Academy of Sciences. 1970. \$17.50.

The proceedings of a conference held by the New York Academy of Sciences in 1969 are reported in this volume. They deal with perception of the outer world, perception of the inner world, perception in abnormal psychological experience, and perception of creativity.

Perception and Its Disorders. Edited by DAVID A. HAMBURG, KARL H. PRIBRAM and ALBERT J. STUNKARD. Baltimore: Williams & Wilkins. 1970. Pp. xi+405. £10.00.

This is a research publication of the Association for Research in Nervous and Mental Disease, and reports the proceedings of a meeting of the Association at the end of 1968. It includes a wide variety of papers on certain highly active areas of current research. The emphasis is mainly on vision. Most normal aspects of perception as well as disturbances are considered.

Contemporary Problems in Perception. Edited by A. T. WELFORD and L. HOUSIADAS. London: Taylor & Francis. 1970. Pp. 175. £3.00.

This book reports the NATO Advanced Study Institute held in Thessaloniki in 1968. Its aim was to collect some of the current strands of thinking on human perception which seem likely to be important in the future on both theoretical and practical grounds. There are three main groups of papers. Those in the first group deal with general approaches and theories. The second group reports specific studies, all of which are aimed at accounting, in terms of stimuli reaching the eye, for features of perception which are often regarded as matters of inference and judgement. They attempt to specify the necessary and sufficient stimuli for certain features of perceptual integration. The last group of papers looks at the relation between perception and action.

This collection of papers is of concern to psychologists and engineers working on problems in ergonomics or human factors.

Hypothesis and Perception. By ERROL HARRIS. London: Allen & Unwin; New York: Humanities Press. 1970. Pp. 395. £5.00.

This book is a sequel to *The Foundations of Metaphysics in Science*, addressing itself to the epistemological questions which the author explicitly left aside in the earlier work. A new theory of scientific method is developed, directly opposed to the theories developed on the basis of Hume's position by such writers as Carnap, Reichenbach, Hempel and Nagel. The empiricist theory is criticized directly, on its own presuppositions, and the author attempts to show that it is internally incoherent. An epistemology of science is presented which looks to C. S. Peirce and R. G. Collingwood as precursors. The author argues that the actual method of thinking employed by scientists is neither inductive nor deductive, but constructive - of systems built up not from particular, theory-neutral observations of 'matters of fact', but always developed from earlier, more limited and less cohesive systems, each of which

is a polyphasic unity. The progress of science is regarded as dialectical, and successive theories are thought to constitute a scale in a progressive, dynamic development.

Image Formation and Cognition. By MARDI J. HOROWITZ. London: Butterworth Group. 1971. Pp. xiii + 351. £5.80.

This book attempts to explain why and when people think in visual images and explores the motives and controls of image formation. The author examines the subject from multiple viewpoints, including those of psychoanalysis, cognitive psychology, and neurobiology. The emphasis is on images in everyday thinking as well as unusual or pathological types of image formation. Both voluntary and involuntary experiences are closely considered.

Mechanisms of Motor Skill Development. Edited by K. J. CONNOLLY. London: Academic Press. 1971. Pp. xv + 393. £6.00.

This study of the mechanisms underlying the development of skilled motor behaviour, mostly in babies and young children, draws on the approaches and techniques of related disciplines. Advances in comparative psychology and the adoption of adequate theoretical models and experimental methods have broken down the old view that children's behaviour was simple and uniform. The book begins with a critical review identifying fundamental problems in earlier work and an evaluation of the maturational hypothesis. It continues with papers on the major issues of the development and learning of motor skills. Interpolated between these are discussions, directly linked to the papers, on separate topics of importance. The book is intended to be of use to teachers, students and research workers in experimental and developmental psychology, developmental biology, ethology and neurology, as well as paediatrics.

Odours. By R. W. MONCRIEFF. London: Heinemann. 1970. Pp. vii + 237. £2.25.

Much less is known about smell than about the other senses, but in the last 10 or 15 years a great deal of research has been undertaken, both academic and industrial, on the subject. This book

reviews how direct methods of physical and physiological experiment have yielded the most useful information.

Assessment of Brain Damage. By ELBERT W. RUSSELL, CHARLES NEURINGER and GERALD GOLDSTEIN. Chichester: Wiley. 1970. Pp. x + 167. £6.25.

The psychological tests for brain damage developed by Halstead and modified by Reitan have been used increasingly in recent years for the diagnosis of brain damage. This book describes the development of neuropsychological keys (patterned after the taxonomic keys used in biology) based on these tests, their application to brain-damaged and non-brain-damaged patients, and an evaluation of how accurately they predict the neurological diagnosis. The validity of the keys was established by comparing the predictions made by them with neurological findings based on neurological examinations, EEG, and other diagnostic procedures. The keys were found to be highly valid not only in predicting presence or absence of brain damage, but whether, if damage existed, it was in the right cerebral hemisphere, the left, or if it was diffuse, and whether it was an acute, static, or congenital lesion. The keys are presented clearly and in such a way that non-professionals can 'run' them with a minimal amount of instruction. In addition to brain damage, this method can be applied to assessment in many areas of psychology.

A computer program is presented in detail and is available to anyone familiar with FORTRAN IV computer language. Only minor revisions are necessary to adapt the program to other computers.

Perspectives in Personal Construct Theory. Edited by D. BANNISTER. London: Academic Press. 1970. Pp. xii + 273. £4.00.

This is a collection of important papers on personal construct theory, and includes chapters by George Kelly, Jack R. Adams-Webber, D. Bannister, Fay Fransella, Dennis Hinkle, Ray Holland, Grahame Leman, J. M. M. Mair, Don Oliver, Phillida Salmon and John Shotter. It should be of major interest to all those concerned with personal construct theory and 'grid' techniques.

A Psychoanalytic Model of Attention and Learning. (Psychological Issues, Volume VI, no. 3, monograph 23.) By FRED SCHWARTZ and PETER H. SCHILLER. New York: International Universities Press; Folkestone, Kent: Bailey Bros. & Swinfen. 1970. Pp. 134. £2.25.

Starting with David Rapaport's postulates about attention and learning, the authors have developed an experimental model which can be subjected to verification. The work is intended to have implications for experimental and clinical psychology and to contribute to the integration of phenomena observed in the laboratory and the therapeutic situation. The authors believe that the strategy of testing selected portions of psychoanalytic theory with the experimental method may have important methodological implications for psychoanalysis.

Causal Thinking in the Child. By MONIQUE LAURENDEAU and ADRIEN PINARD. New York: International Universities Press. 1970. Pp. xvi + 293. \$7.50.

This study of the development of causal thinking is based on the examination of a group of 500 children aged from 4 to 12. They were individually tested with questionnaires and material similar to those used by Piaget, but adapted to the requirements of systematic standardized testing. The specific areas investigated are the concept of dream, the concept of life, the movement of clouds, and the floating and sinking of objects. The data yielded by this investigation are analysed with care and ingenuity, and ample illustrations from the children's protocols demonstrate the authors' methodological approach.

On the basis of their results the authors subject earlier investigations of causal thinking to a critical examination, and clarify many apparently contradictory findings.

Professor Piaget has written a preface to the

book, and confesses to his own surprise at realizing the value of the authors' approach.

The Development of the Concept of Space in the Child. By MONIQUE LAURENDEAU and ADRIEN PINARD. New York: International Universities Press; Folkestone, Kent: Bailey Bros. & Swinfen. 1970. Pp. ix + 465. \$12.50; £6.25.

This volume presents a detailed critical analysis of five experimental tests, devised by Piaget, and designed to shed light on the methods by which children form their concepts of space. The tests are concerned with stereognostic recognition of objects and forms, construction of a projective straight line, localization of topographical positions, concepts of left and right, and coordination of perspectives.

The tests were administered to a substantial sample of subjects at each age-level between the ages of 2 and 12, distributed at 6-month intervals up to the age of 5 years, and at 12-month intervals thereafter.

Minnesota Symposia on Child Psychology. Volume 4. Edited by JOHN HILL. Minnesota: University Press; London: Oxford University Press. 1970. Pp. ix + 275. £2.40.

This volume contains six papers by eight contributors: 'The Effects of Early Life Experiments on Developmental Processes and Susceptibility to Disease in Animals' by Robert Ader; 'The Antecedents and Adult Correlates of Academic and Intellectual Achievement Effort' by Virginia C. Crandall and Esther S. Battle; 'The Role of Peer-Group Experience in Moral Development' by Edward C. Devereux, Jr.; 'The Development of Motor Skills and Social Relationships among Primates through Play' by Phyllis Jay Dolhinow and Naomi Bishop; 'Systems of Perceptual and Perceptual-Motor Development' by Herbert L. Pick, Jr.; 'Mental Elaboration and Proficient Learning' by William D. Rohwer, Jr.

The Child and Reality. By T. A. RATCLIFFE.
Hemel Hempstead: Allen & Unwin. 1970.
Pp. 141. £2.00.

The subjects dealt with in this book include residential work with children, school phobia, adolescence, the problem family, relationship therapy and casework, the three-generation family, and child guidance techniques. The author relates basic theoretical concepts to reality and practical situations, emphasizing the importance of environmental factors in understanding and working with children.

Modern Psychopathology. By THEODORE MIL-
LON. Philadelphia and London: Saunders.
1969. Pp. xx+681. £4.57½.

This substantial volume deals with historical trends, contemporary theories, clinical analysis, biogenic factors, psychogenic factors, psychopathological personalities, symptom disorders, pathological behaviour reactions, biophysical defects, biological approaches to treatment, and psychological approaches to treatment. A comprehensive bibliography is appended. The work attempts to provide the student with a logical succession of data and ideas basic to his understanding of pathological behaviour.

Symptoms of Psychopathology: a Handbook.
Edited by CHARLES G. COSTELLO. New York
and Chichester: Wiley. 1970. Pp. 679.
£7.50.

This book contains writing, by prominent workers in the field, on the symptoms of psychopathology in both children and adults. The articles attempt a comparison and evaluation of the current aetiological theories and assessment and modification techniques. The sections include cognitive and perceptual disorders, disorders of affect, disorders of behaviour and psychosomatic disorders.

Treatment or Diagnosis: a Study of Repeat Prescriptions in General Practice. By MICHAEL BALINT, JOHN HUNT, DICK JOYCE, MARSHALL MARINKER and JASPER WOODCOCK. London: Tavistock Publications. 1970. Pp. xviii+182. £2.75.

The continual repetition of prescriptions, often over a period of many years, is discussed in this

book. It is an aspect of medicine which has previously escaped measurement and research, and this book consists of a series of studies concerned with the prevalence of repeat prescriptions in a number of general practices, as well as with an examination of the doctor-patient relationship involved in these cases.

The Leaves of Spring. By AARON ESTERSON.
London: Tavistock Publications. 1970. Pp.
xxxv+278. £3.15.

The author attempts an understanding of madness in our society, and the development of a method of studying families and persons in their social contexts. The first part of the book contains a major phenomenological study of a mad family, and the second part is devoted to a discussion of the author's methodology and the principles embodied in it. He states the case for a new type of professional practice to deal with personal and social problems, and refers to this as a science of social intervention. He discusses its possible principles in relation to such microsocial situations as the psychoanalytic relationship and the study of families, and to macrosocial situations such as social revolutionary struggle.

Loss and Grief: Psychological Management in Medical Practice. Edited by BERNARD SCHOENBERG, ARTHUR C. CARR, DAVID PERETZ and AUSTIN H. KUTSCHER. New York and London: Columbia University Press. 1970. Pp. xi+398. £5.65.

A symposium held at Columbia, including nurses, doctors, psychiatrists, psychologists, sociologists, social workers and theologians, is reported in this volume. It reflects the increasing interest in the practice and teaching of a more comprehensive approach to the care of patients in different branches of the health professions. It is intended for those who are concerned with education in this field.

Concepts of Depression. By JOSEPH MENDELS.
London: Wiley. 1970. Pp. xiii+124. £2.50;
paper, £1.35.

This brief volume attempts to present a review of all the important aspects of depression and mania. It includes material from behavioural, pharmacological, biochemical, psychophysiological, genetic, and therapeutic sources.

The Human Aspects of Sexual Deviation. By EUSTACE CHESSE. London: Jarrolds, 1971. Pp. 256. £2.25; published simultaneously as Arrow Paperback, 40p.

Dr Chesser discusses sexual practices and behaviour which would appear to deviate from the so-called norm. In actual practice normality almost defies definition – as do both deviation and perversion. The author attempts to show that it is society's attitude to varying forms of sexual expression which largely determines what we regard as normal and abnormal. Actions abhorrent to some can be enjoyed by others; but, the author argues, there is a great difference between acts which are antisocial and those which are merely unusual and perhaps bizarre.

Sacher-Masoch: An Interpretation. By GILLES DELEUZE. (Together with the entire text of *Venus in Furs*.) London: Faber & Faber. 1971. Pp. 248. £2.50.

In this study of Leopold von Sacher-Masoch, whose mystical, erotic stories led Krafft-Ebing to immortalize his name, masochism is not regarded as the opposite of sadism, but as something much more subtle and complex than the enjoyment of suffering pain. The author applies the techniques and knowledge of a psychoanalyst to a literary criticism of Masoch's writings, on the principle that it is from literature that the original definitions come and so it is to the literary values of de Sade and Masoch that we must return to discover their similarities and differences.

Included with Deleuze's *Interpretation* is Sacher-Masoch's most famous novel, *Venus in Furs*, which is published here in the first complete and accurate version to appear in this country.

Active-Passive: the Crucial Psychological Dimension. By EDRIKA FRIED. New York: Grune & Stratton. 1970. Pp. ix + 222. \$7.95.

The author takes issue with the classical psychoanalytic assumption that the chief human goal is freedom from tension. The ideals of activity and vitality, and the blocks in their path, are the subject of this book by a practising psychotherapist. The author regards passivity as one of the most insidious and pervasive threats to a full life and emotional well-being.

Psycho-Analytic Insight and Relationships: a Kleinian Approach. By ISCA SALZBERGER-WITTENBERG. London: Routledge & Kegan Paul. 1970. Pp. xvii + 178. £1.50.

The author attempts to demonstrate, through theoretical exposition and the use of case material, the ways in which Melanie Klein's main concepts and theories may illuminate the practice of social casework. While these theories are often complex and controversial, this account is aimed at enabling social workers to judge the relevance of the Kleinian approach for themselves.

The Hands of the Living God. By MARION MILNER. London: Hogarth Press. 1969. Pp. xxxi + 444. £3.15.

This is the story, by the author of *A Life of One's Own* and *On Not Being Able to Paint*, of the treatment, lasting over 20 years, of a single patient who suddenly and spontaneously discovered the capacity to do doodle drawings. It was partly for this reason and also in order to clarify, both for herself and for others, what she was learning from her patients that Mrs Milner wrote this book. However, the author sees the ultimate stimulus coming from the drawings themselves, with their deep unconscious perception of the nature of the battle between sanity and madness. Over 150 of the patient's drawings have been reproduced, and it is these which, closely linked with Mrs Milner's sensitive and lucid record of the therapeutic encounter, give the book a unique and compelling interest.

Research at the Hampstead Child-Therapy Clinic and Other Papers. By ANNA FREUD. London: Hogarth Press. 1970. Pp. xii + 575. £5.00.

This is the fifth volume in a series which ultimately will constitute the complete collection of the writings of Anna Freud. The material that it contains was written during the period 1956–1965, and much of it has never been published before. For example, the volume contains Anna Freud's hitherto unpublished communications outlining research projects and activities at the Hampstead Child-Therapy Clinic. The volume includes papers addressed both primarily to psychoanalysts and those meant for non-analytic audiences as well.

Basic Psychoanalytic Concepts on Metapsychology, Conflicts, Anxiety and Other Subjects. The Hampstead Clinic Psychoanalytic Library. Volume IV. Edited by HUMBERTO NAGERA. Hemel Hempstead: Allen & Unwin. 1971. Pp. 233. £3.25.

Seventeen subjects have been selected on the basis of their relevance for the understanding both of psychoanalytic theory and of human behaviour in general. The volume outlines the development of Freud's theories regarding such subjects as fixation, regression, cathexis, conflicts, anxiety, ambivalence, reality testing, transference and countertransference. Some of these subjects have been chosen because of the many misconceptions and misunderstandings which surround them. As in previous volumes, the development of each concept is described from its conception to Freud's final formulation and detailed references are given.

Basic Psychoanalytic Concepts on the Theory of Instincts. The Hampstead Clinic Psychoanalytic Library, Volume III. Edited by HUMBERTO NAGERA. Hemel Hempstead: Allen & Unwin. 1971. Pp. 136. £2.50.

This volume describes in condensed but detailed form Freud's development of the theory of instincts. Freud reformulated and amplified his theory at several points during his lifetime. Such periodical amplifications and reformulations were made necessary by a number of factors, for as Freud gained experience he not only developed fresh insights, but also was faced with the problem of explaining the increasing amount of clinical phenomena that offered itself for examination under the psychoanalytic microscope.

Modern Psychoanalysis. Edited by JUDD MARMOR. London: Basic Books. 1970. Pp. xiii + 732. £7.00.

In this extensive assessment of the emerging patterns of psychoanalytic thought, sponsored by the American Academy of Psychoanalysis, 34 authors explore new approaches to psychoanalytic theory and therapy, and examine the growing interaction between psychoanalysis and other behavioural sciences.

The book attempts to demonstrate how some thinkers in psychoanalysis are bringing their

discipline into the mainstream of psychobiological thought, making use of systems theory, information processing, the constructs of adaptation and learning, and other tools and findings.

The World Biennial of Psychiatry and Psychotherapy. Volume I. Edited by SILVANO ARIETI. London: Basic Books. 1971. Pp. xiii + 622. £9.35.

This is the first volume in a major new series in the field of psychiatry. Under the editorship of Dr Arieti, with the guidance of an international advisory board, *The World Biennial* will, every two years, attempt to present the latest developments and the most valuable contributions made in psychiatry and related fields throughout the world. Volume I covers four main areas: new developments in psychiatric theory, clinical studies, childhood and youth, and biological studies in psychiatry.

Clinical Psychiatry. Third Edition. By ELIOT SLATER and MARTIN ROTH. London: Baillière, Tindall & Cassell. 1969. Pp. xvi + 904. £7.00.

This major work, first published in 1954, now appears in its third edition. The new edition includes further recognition of the importance of epidemiology in mental disorder, its social consequences and the problems of rehabilitation. The relevance of the advances in understanding the physiological and biochemical basis of mental disorder to the therapeutic approach in various states is discussed, and much of the text of the book has been rewritten or revised. A new chapter on social psychiatry reflects the increasing importance attached to this subject. Most of the other chapters have also been radically changed, and many new illustrations have been included.

Psychiatric Dictionary. Fourth Edition. By LELAND E. HINSIE and ROBERT J. CAMPBELL. London: Oxford University Press. 1970. Pp. ix + 816. £7.00.

In the fourth edition of this work the authors have met the demands of an increasing vocabulary and the revisions of archaic definitions with the addition of 1400 terms, and the revision of over 1000 more, expanding the present volume to nearly 10,000 psychiatric terms. The new entries

cover topics in the areas of community and social psychiatry; fundamental genetics; new knowledge of protein chemistry and of enzyme action and immunity; the neurophysiology of sleep, dreaming, learning, and memory; differentiation of various types of mental retardation; rehabilitation and social therapy; primary prevention of mental disorder; drug dependency and drug abuse; developmental studies; crisis intervention, brief therapy and behaviour therapy; and psychopharmacology, including tranquillizers, thymoleptics, and lithium. Throughout, definitions are given in the form of clinical observations, and are so worded that their meaning may easily be grasped by the layman as well as the professional.

General Systems Theory and Psychiatry. Edited by WILLIAM GRAY, FREDERICK J. DUHL and NICHOLAS D. RIZZO. London: Churchill. 1969. Pp. xxii + 481. £6.25.

This volume focuses on the history and development of general systems theory, the evolution of psychiatric interest in the theory, and the work of its pioneers. The first part introduces general systems theory in relation to broad areas such as living systems, symbolism and human communication. The second part deals directly with the application of the theory to psychiatric areas, including a unifying theory of cognition, information exchange in the time domain, and an integrative conception of mental disorder. The final part attempts to demonstrate the variety of clinical applications of this theory.

Psychiatry for Social Workers. By ALISTAIR MUNRO and WALLACE McCULLOCH. New York and London: Pergamon Press. 1969. Pp. xvi + 283. \$6.50 (£2.10); flexi-cover, \$4.75 (£1.50).

While this is not a comprehensive textbook of psychiatry, it is a work specially tailored for social workers in all fields who are bound to come into frequent contact with situations where a psychiatric problem is an important factor. The authors attempt to give a well-balanced and non-sectarian view of psychiatry, stressing those aspects which are of special interest or importance to the social worker.

Religion and Medicine: a Discussion. Edited by M. A. H. MELINSKY. London: SCM Press. 1970. Pp. viii + 146. £1.25.

The Institute of Religion and Medicine was founded in 1964 to provide a forum for discussion between doctors, members of associated therapeutic professions and religious leaders, to promote mutual understanding for the benefit of those in need. This book collects together a number of papers, the majority of them published for the first time, which represent varied aspects of the thinking of its members.

LSD, Marihuana, Yoga and Hypnosis. By THEODORE X. BARBER. Chicago: Aldine. 1970. Pp. xii + 337. \$8.95.

This book attempts to explain the psychological and physiological effects of the major psychedelic drugs as well as the minor ones. Yoga and hypnosis are included. After a review of the scientific research on the subject, the author questions long-held assumptions on each of these topics, and attempts to analyse the phenomena associated with them. He questions the hypothetical constructs that have been traditionally used in theories of the phenomena, and delineates the antecedent variables that are causally related to them.

Drug Dependence. Advances in Mental Science, Volume 2. Edited by ROBERT T. HARRIS, WILLIAM M. McISAAC and CHARLES R. SCHUSTER, JR. Austin and London: University of Texas Press. 1970. Pp. xiv + 342. £4.75.

This volume brings together such diverse groups as physicians, lawyers, research scientists, social workers, and representatives of the Narcotics Bureau of the Department of Justice in the U.S.A., in an effort to present a cross-section of current opinion on drug use and drug dependence, and the results of recent research in the various fields. The book includes material on the treatment of addicts by the use of narcotic antagonists and the continuing search for strong analgesics with reduced dependence capacity.

Drugs from A to Z: a Dictionary. By RICHARD R. LINGEMAN. London: Allen Lane The Penguin Press. 1970. Pp. 262. £2.50.

The author lists natural and pharmaceutically produced drugs, describing their properties and effects, their chemical uses, and the likely consequences of misuse. Slang terms, as well as more orthodox names, are given, and an attempt is made to relate the argot to the user's attitude towards his drug, to the mystique of drug-taking and its sociological repercussions.

Use is also made of quotations from literary sources showing both how a particular term is used and how the act of drug-taking has been turned from a private experience into the shared mythology of a group. The appendices list the non-synthetic derivatives of opium, morphine and cocaine; and the generic and trade names of barbiturate, amphetamine and combination drugs available in the United Kingdom.

Childhood and Destiny: the Triadic Principle in Genetic Education. By JOACHIM FLESCHER. New York: International Universities Press; Folkestone, Kent: Bailey Bros. & Swinfen. 1970. Pp. 349. £5.00.

It is the author's firm conviction that the principles outlined in this book, if applied at least to the extent to which we practise the most elementary rules of physical hygiene throughout the world, will preserve future generations from crowding psychiatric wards and prisons.

The Theory and Practice of Mental Health Consultation. By GERALD CAPLAN. London: Tavistock Publications. 1970. Pp. xiii + 397. £3.25.

Professor Caplan defines consultation and differentiates it from other, sometimes similar, methods used by mental-health clinicians. He describes techniques appropriate in a wide range of settings, and provides case material and analysis of many examples of consultation procedure. Based on 18 years of research and practice, this work provides both a theoretical basis for consultation and a methodology of techniques appropriate to various situations.

Program Evaluation in the Health Fields. Edited by HERBERT C. SCHULBERG, ALAN SHELDON and FRANK BAKER. New York: Behavioral Publications. 1970. Pp. xviii + 582. \$19.95.

This is a reference work designed for both researcher and practitioner concerned with evaluating health programmes. Some three dozen papers explore the areas of interest to both. The administrator is informed of the complexities in programme evaluation and is helped to make more realistic judgements. The researcher finds questions raised by the gaps between concepts and techniques, areas in which he may attempt to develop solutions. The goal attainment model and the systems model are identified as the two major approaches to evaluations. There are five sections, dealing with 'Concepts and General Issues', 'Research Designs', 'Evaluation Techniques and Indexes', 'Examples of Programme Evaluation', and the 'Implementation of Research Findings'.

Mental Illness and Civil Liberty. By CYRIL GREENLAND. Occasional Papers on Social Administration, no. 38. London: Bell. 1970. Pp. 126. £1.60.

This study of the operation of Mental Health Review Tribunals in England and Wales is almost entirely concerned with describing how the tribunals function in practice as well as theory. The first chapters outline the problem of mental illness and civil liberty, tracing the development of the Mental Health Act 1959, illustrating the common ways of compulsory admission and discharge from mental hospitals and the basic facts about MHRT rules and procedures. A description of an empirical research follows, in which the study of 1250 tribunal applications received in 1963 is described. A follow-up study of 50 patients who were discharged from hospital by a tribunal is included. A number of defects of the tribunal system, in particular the lack of protection for certain patients who cannot initiate an appeal against detention, are described. The author argues that the Mental Health Review Tribunal should be replaced by an independent commission.

The Practice of Sociotherapy. By MARSHALL EDELSON. London: Yale University Press. 1970. Pp. 345. £5.65.

The author regards the sociotherapist as a new kind of clinician. He may be a psychiatrist, psychologist, nurse, social worker, nursing aide, administrator, group worker or occupational therapist, and faces tasks requiring special conceptual tools and skills. The book presents both the theoretical framework and the day-to-day working of the sociotherapist, based on the analysis of the daily log, over a period of two years, of community meetings at a small psychoanalytically orientated psychiatric hospital.

Learning Foundations of Behavior Therapy. By FREDERICK H. KANFER and JEANNE S. PHILLIPS. New York and London: Wiley. 1970. Pp. xi + 642. £4.85.

This book introduces the experimental bases of behaviour modification in such a way that the reader with little sophistication in psychology may, it is claimed, gain a practical understanding sufficient not only to apply specific methods of behaviour therapy, but also to make innovations in practice or research.

Four Psychotherapies. By LEONARD HERSHER. London: Butterworth. 1970. Pp. xii + 152. £2.60.

This is a book about the theory and practice of client-centred therapy, rational-emotive therapy, behaviour therapy, and psychoanalysis. It represents the proceedings of an 'Institute on Psychotherapy', held in 1965, in which representatives of these four 'schools' of psychotherapy discussed their theories.

Experience in Groups. By W. R. BION. London: Tavistock Publications. 1970. Social Science Paperback. Pp. 198. 75p.

This is a paperback reprint of the book first published in 1961.

Treatment for Children. By DAVID MACLAY. Hemel Hempstead: Allen & Unwin. 1970. Pp. 247. £3.00; paper, £2.25.

In this book the author describes the work and techniques used in a modern child guidance clinic.

The methods used in helping emotionally disturbed children and their parents are explained, together with the causes of psychological stress. The symptoms and treatment of neurosis, delinquency and educational and personal problems are discussed. This is a book written by a non-analyst with a wide experience of therapy, and is directed towards those psychologists and psychiatrists who treat children but are not analytically trained. It also aims to be of interest to parents, teachers, social workers and play leaders who are not especially concerned with problems of children, but who wish to deepen their understanding of child behaviour.

Mental Illness in Childhood. By V. L. KAHAN. London: Tavistock Publications. 1971. Pp. xix + 219. £3.00.

The needs of children suffering from severe emotional disturbance cannot always be met from the resources of the normal home or educational setting. Such children often fail to respond to treatment in a psychiatric ward. The unit described in this book was set up to provide residential treatment for a group of such children, whose diagnoses included various forms of psychosis and subnormality as well as behaviour and personality disorders.

The author gives a detailed account of the management and treatment of the children under his care at West Stowell House between 1959 and 1965, a period during which a small, conventional subnormality hospital was transformed into a 'family-based', domestic living-unit providing intensive care to support the child while therapeutic and educational processes were carried out. The use of drugs, in these circumstances, could be radically reduced, permitting more accurate assessment of personality and greater refinement of diagnosis. Moreover, the effects of institutionalization were diminished, and education became a possibility in place of mere training. Sixteen selected case histories are presented in depth, but the study is based on a total of 71 cases treated.

Troubled Children in a Troubled World. By EDITH BUXBAUM. New York: International Universities Press. 1970. Pp. 341. \$6.00.

Dr Buxbaum, who is a distinguished educator and child psychoanalyst, has rewritten many of her previously published papers and added new

ones for this book. The theoretical papers deal principally with problems of psychosexual development, ego functions, separation and identity, and aggression. These are substantiated and developed by extensive clinical material in the second part of the book. The final section contains the author's presentation of her first-hand observations of kibbutz-raised children, made when she served as supervisor and consultant to the therapists and educators at Oranim, the child guidance clinic of kibbutzim in Israel. The developmental and emotional problems of such kibbutz children throw particular light on sleeping disturbances, separation anxiety, toilet training, and sexual problems of adolescents.

Toward a Typology of Juvenile Offenders: Implications for Therapy and Prevention. By SHELDON and ELEANOR GLUECK. New York: Grune & Stratton. 1970. Pp. xvi + 203. \$8.75.

This work is a continuation of the efforts of Sheldon and Eleanor Glueck to explain the nature of delinquency, this time through the search for an adequate 'typology' of the juvenile offender. The types ranged along a continuum from those whose prognosis is most favourable to the 'core type' delinquent who has nine in ten chances of becoming a repeating delinquent, or later given to criminality as a style of life. The emphasis is on the earliest possible location of the 'high risk child' in our society.

Parents and Family Planning Services. By ANN CARTWRIGHT. London: Routledge & Kegan Paul. 1970. Pp. x + 293. £3.00.

This work is aimed at answering the question of how family planning services can be organized to reduce unwanted pregnancies. A sample of parents were asked about their contraceptive practices, their views on different methods of birth control and their experience and opinions of different sorts of services. Professional workers in the field were also asked about their views and practices, and the juxtaposition of the views of parents and professionals shows some of the reasons why people do not use effective methods of birth control and suggests ways in which they could be helped to do so.

Marriage in Life and Literature. By ROBERT SEIDENBERG. New York: Philosophical Library. 1970. Pp. ix + 307. \$5.95.

The author takes the view that people do not only bring their problems into marriage, but that marriage brings problems to people as well. He suggests that there has been an inadequate understanding of the erosive aspects of marriage for certain individuals. He believes that in certain cases the renunciation of living asked of the woman is excessive, may lead to mental illness, and often results in a gradual mental deterioration from sensory deprivation. The book takes examples from both clinical material and belles-lettres to demonstrate some of the attritions which occur in marriage as well as the prospects for growth.

Contraception and Sexual Life. By L. P. D. TUNNADINE. London: Tavistock Publications. 1970. Pp. xv + 80. £1.25; paper, 60p.

In order to explore more effective ways of helping those seeking contraceptive advice, a group of doctors working for the Family Planning Association began, in 1960, an attempt to develop psychophysical skills to meet the emotional as well as the physical problems their patients revealed. In the course of this study, knowledge was gained of the nature of sexual anxiety in women, and of frigidity itself. These were problems involving the interaction of physical and emotional factors that could best be approached by a technique combining psychotherapeutic insight with the normal gynaecological examination. In this book the author describes the use of the technique, with case illustrations drawn from her own and her colleagues' clinics.

Facts about Sex: a Basic Guide. By SOL GORDON. New York: John Day Company. 1970. Pp. 48. \$3.95.

This is a book about sex for young people who really do not like to read but who want to know about the subject. It is short, direct, concrete and enlightening, with practical advice and frank explanations.

A Hundred Years of Psychology. By J. C. FLUGEL and DONALD J. WEST. New York: International Universities Press. 1970. Pp. 394. \$12.00.

This is the substantially enlarged, revised edition of a work which made its appearance more than three decades ago. It brings up to date a developmental history of the science of psychology. For this third revised edition, Dr Donald J. West has undertaken needed revisions and has also extended and updated the concluding section.

Explanations in the Behavioural Sciences. Edited by ROBERT BORGER and FRANK CIOFFI. London: Cambridge University Press. 1970. Pp. xii + 520. £5.00.

This is a presentation of conceptual disagreements in the behavioural sciences. The editors asked a number of distinguished contributors each to put forward a point of view, others to write critiques of these expositions, with final replies by the first authors. The chapters included discuss the relevance of psychology to the explanation of social phenomena (by George C. Homans and Peter M. Blau), the Skinnerian analysis of behaviour (by R. A. Boakes, M. S. Halliday and Karl H. Pribram), explanation and the concept of personality (by H. J. Eysenck and D. Bannister), problems of explanation in linguistics (by Noam Chomsky and Max Black), Freud and the idea of pseudo-science (by Frank Cioffi and B. A. Farrell), conditioning and behaviour (by D. W. Hamlyn and A. J. Watson), and situational individualism and the emergent group-properties (by J. O. Wisdom and Robert Brown).

Criticism and the Growth of Knowledge. Edited by IMRE LAKATOS and ALAN MUSGRAVE. London: Cambridge University Press. 1970. Pp. viii + 282. £3.50.

This volume arose out of a symposium on the work of Thomas Kuhn, with Karl Popper in the chair, at an international colloquium held in London in 1965. The book begins with Kuhn's statement of his position, followed by seven essays offering criticism and analysis, and concludes with Kuhn's reply.

Determinism, Free Will, and Moral Responsibility. Edited by GERALD DWORKIN. Hemel Hempstead: Prentice-Hall International. 1970. Pp. vi + 217. £3.00; paper, £1.00.

This book contains a balance of historical and contemporary selections and of both positive and critical material. The problem of free will and determinism is an ancient one, but it has acquired new interest in the light of substantial progress in psychology. This volume, besides exploring the relations between these two concepts, grapples with the meaning and justification of deterministic and libertarian claims.

The Theory of Meaning. Edited by ADRIENNE and KEITH LEHRER. Hemel Hempstead: Prentice-Hall International. 1970. Pp. viii + 216. £3.00; paper, £1.00.

Few philosophical problems have attracted as much interest, or made as much progress, in recent years, as has the theory of meaning. This volume, after dealing with the shortcomings of the many traditional theories of meaning, probes the strengths and weaknesses of the speech-act and theoretical linguistic approaches to meaning.

Readings in the Philosophy of Science. Edited by BARUCH A. BRODY. Hemel Hempstead: Prentice-Hall International. 1970. Pp. xviii + 367. £5.00.

This anthology is divided into three sections. Section I contains scientific explanation and prediction. Section II relates to the structures and functions of scientific theories, while Section III is concerned with the confirmation of scientific hypotheses. These problems have been chosen because of their central position in regard to the philosophy of science. In all, this anthology provides readings on the major issues in this area of philosophy. These are presented with criticisms of each position included. Important recent works in the area, with particular reference to post-World War II studies, are emphasized.

The Principles of Scientific Thinking. By R. HARRÉ. London and Basingstoke: Macmillan. 1970. Pp. viii + 324. £4.50.

The author seeks to establish the principles at work in scientific thinking, and attempts to develop them in a systematic way as an alternative theory to that of the logical empiricists and positivists. The principles of model-building as an analytical tool are extensively explored, and roles for the rational discipline of the imagination are developed. In this way the role of the imagination in constructing theories is emphasized in opposition to the inductive approach of the logical positivist tradition, care being taken not to slip into psychologism.

Behavioural Worlds. By P. G. HERBST. London: Tavistock Publications. 1970. Pp. xiv + 248. £2.50.

Using classical physics as a scientific model, the author assumes that it is possible to formulate laws and construct measurement scales that would be applicable to every person or every group. Results show, on the contrary, that every person and every group has the characteristics of a behavioural universe, evolving its own laws and

measurement scales, which, moreover, can change with time. The present volume describes techniques for the systematic and quantitative study of single cases as applied to the consideration of autonomous group functioning, pupil-task relationships, family processes, and organizational behaviour. It constitutes an extension of a theory and methodology first set out in the author's *Autonomous Group Functioning*, published in 1962.

Language, Minds and Knowledge. By ROBERT HOFFMAN. London: Allen & Unwin. 1970. Pp. 164. £3.50.

The author begins his inquiry by attempting to answer the questions 'What is a philosophical argument?' 'Why accept one philosophical theory rather than another?' He analyses different kinds of philosophical argument, and suggests criteria for rejecting defective philosophical theories outright, and criteria for choosing between acceptable, but competing, theories. He then distinguishes six senses of 'a private language' and discusses the question of whether or not there can be a private language. This discussion leads to an analysis of solipsism and to an explanation of the concept of mind and an analysis of the mind-body complex.

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The oedipal situation in male transsexualism

BY LAWRENCE E. NEWMAN AND ROBERT J. STOLLER*

Studies of male transsexuals indicate that the disorder starts in infancy as a primitive and pervasive identification with mother's femaleness. The basis for this pronounced identification is the intense, blissful, symbiotic relationship this mother establishes with her new son – a relationship characterized by endless hours of physical and emotional closeness, continuous, uninterrupted preoccupation with the child and instant gratification of all needs. The chronic unhappiness, penis envy and special kind of bisexuality characteristic of the mother which underlies her overwhelming fascination and love for her son has been described elsewhere (Stoller, 1968). By the third year of life the profound femininity of the future male transsexual is already unmistakable: he wants to dress continuously as a little girl and is miserable if made to wear boys' clothing; his mannerisms are feminine; he takes the girl's roles in fantasy games and he announces that he wants to grow up to become a woman. Medical technology – the recent availability of female hormones and of genital reassignment surgery – has made it possible for the adult male transsexual to approximate his childhood wish by transforming his body in a female direction. Typically the adult transsexual then dresses and lives as a woman, passing in society without detection.

If this profound and natural-appearing femininity (transsexualism) is already established in the boy's personality by his third year, what is the nature of his oedipal experience? In other disorders of sexuality, the Oedipus complex exerts a decisive aetiological influence. And so we would expect it to be extremely important in transsexualism also. In fact, the oedipal period is significant in male transsexualism in that it fails to modify, alter or

distort the *already existing* femininity of the boy. The oedipal situation in male transsexualism is remarkable in that evidences of oedipal conflict – incestuous feelings, castration anxiety and identification with the parent of the same sex – are not seen. It is this absence of significant oedipal conflict, we believe, which permits the feminine identity of the child to develop thereafter in such undistorted form. We attribute the absence of oedipal anxieties to abnormalities in the family situation, especially the physical absence and lack of emotional involvement of the father and the continuing symbiosis with the mother. Later we shall note how a male therapist's intervention during the oedipal period may alter the situation by setting in motion reparative oedipal dynamisms.

During the past six years we have been studying the phenomenon of male transsexualism *in statu nascendi* by longitudinal observations of extremely feminine boys of oedipal age, eight of whom have been in treatment in our clinic. These little boys manifest in behaviour and fantasy the findings which characterized the boyhoods of the most feminine adult male to female transsexuals we have studied. They prefer to dress as girls, love feminine adornment, dislike dressing as a boy or playing with boys. They are feminine in gesture and mannerism, insist on taking a female role in fantasy games and wish fervently that they could grow up to become not men but women. Our clinic data indicate that adult male transsexuals have the same childhood as these little boys (Stoller, 1968).

Before proceeding it is important that we point out that the absence of signs of oedipal conflict in the little boys we are studying must not be construed to mean that we find these patients free of conflict. On the contrary, they suffer tension and sadness. But these symptoms

* Gender Identity Research Clinic, Department of Psychiatry, UCLA School of Medicine.

appear in response to pressures exerted by the outside world against the little boy's femininity; for example, ridicule by other boys who call the patient a 'sissy' or the disapproval of teachers and neighbours. Not infrequently these external pressures cause the child to isolate himself at home and to continue his feminine play activities and cross-dressing in the protected environment created and still supervised by his mother.

THE ABSENCE OF EVIDENCE OF OEDIPAL CONFLICT IN THE TRANSEXUAL BOY

The oedipal situation in the families of these boys is most unusual. Father absents himself from home, avoids emotional involvement with his wife or the patient, and does not present himself as a rival for mother's affection or as a model for masculine identification. The mother, happy to gratify her son's feminine wishes and fearful of losing his love by opposing him, makes no effort to introduce masculinity into his life. Moreover, she enjoys his femininity and uses it as a basis for common interests and understandings. These boys are usually not brought for treatment on their parents' initiative (neither parent being particularly concerned about the femininity of their son) but because of pressures exerted by others, usually nursery-school teachers or neighbours, who express their concern about the boy's obviously abnormal behaviour.

The transsexual boy passes through the years in which in other boys' oedipal dynamics are ordinarily active without altering his femininity or his relationship to his parents. As he grows older and sees that other boys of his age disapprove of his feminine behaviour, he begins to play only with little girls willing to accept him as a feminine companion, sharing in fantasy games of caring for dolls or playing 'house'. Under the protection of his mother at home he continues to enjoy dressing himself up, applying make-up as if he were a beautiful woman and walking around in her high-heeled shoes. Although an enjoyable and preferred activity, cross-dressing is not an *erotic* ex-

perience for these boys. Dressing as a girl does not cause flushing, penile erections or other evidence of sexual excitement. (Similarly adult male transsexuals do not respond fetishistically to female clothing.)

Of great importance is the failure of these boys to develop pleasurable interest in their penises; they do not masturbate. Where other boys enjoy directing a stream of urine while standing erect, these boys sit down to urinate like girls. Sometimes they manifest their dislike for their male genitals by hiding them between their thighs while they walk around at home in a state of undress. The wish to be rid of their genitals and instead to have those of a little girl is conscious and openly stated by the child.

For all their femininity, however, these boys are not psychodynamically like oedipal girls. The latter are romantic, seductive or maternal with their father (more or less). They show evidence of deep feeling for father and are rivalrous towards mother while also increasing their identification with her. The extremely feminine boy shows none of this. He is preoccupied instead with outer aspects of the feminine role – especially clothing, hair style and adornment – rather than with the object relationships characteristic of normal boys or girls during this period.

THE OEDIPUS COMPLEX OF A MASCULINE BOY

At this point, let us contrast the oedipal period of the transsexual boy with that of a masculine boy. In his case report on the phobia of a five-year-old boy, Freud describes the development of an Oedipus complex and how oedipal conflict is resolved via symptom formation (Freud, 1909).

Little Hans, as you recall, developed a phobia of horses. This symptom appeared with the displacement of castration anxiety, the horse symbolically representing the feared castrator. Freud describes the unmistakable masculinity of Little Hans:

...he treated the girls in a most aggressive, masculine and arrogant way, embracing them and kissing them heartily – a process to which Berta in

particular offered no objection. When Berta was coming out of the room one evening he put his arms around her neck and said in the fondest tones: 'Berta, you *are* a dear!' This, by the way, did not prevent his kissing the others as well and assuring them of his love. He was fond, too, of the 14-year-old Mariedl – another of our landlord's daughters – who used to play with him. One evening as he was being put to bed he said: 'I want Mariedl to sleep with me!' (p. 16).

Prior to the onset of the phobia, Hans showed great curiosity about sexual matters, especially interest in his penis and a desire to learn about others' 'widdlers'. Once when she found him masturbating, his mother threatened him with castration. Freud writes:

Meanwhile his interest in widdlers was by no means a purely theoretical one; as might have been expected, it also impelled him to *touch* his member. When he was 3½ his mother found him with his hands to his penis. She threatened him in these words: 'If you do that, I shall send for Dr A. to cut off your widdler. And then what'll you widdle with?' Hans replied: 'With my bottom' (p. 8).

Freud points out that this initial threat of castration did not at the time it was made produce any symptoms.

Several months after this occurrence Hans first learned, through his father's explanation, that *girls did not have penises*. Freud writes:

At the time it [the threat of castration] was made, when he was 3½, this threat had no effect. He calmly replied that then he should widdle with his bottom. It would be the most completely typical procedure if the threat of castration were to have a *deferred* effect, and if he were now, a year and a quarter later, oppressed by the fear of having to lose this precious piece of his ego... The piece of enlightenment which Hans had been given a short time before to the effect that women really do not possess a widdler was bound to have had a shattering effect upon his self-confidence and to have aroused his castration complex. For this reason he resisted the information, and for this reason it had no therapeutic results. Could it be that living things really did exist which did not possess widdlers? If so, it would no longer be so incredible that *they could take his own widdler away, and, as it were, make him into a woman!* (pp. 35–6; our italics this last only).

Freud emphasizes that the threat of castration for Little Hans was capable of exerting its full effect only after he became aware of the difference between the sexes and understood that it was his penis which signified that he was a male. Since he was masculine in personality – which is to say, very attached to the idea of being a male – the threat of losing male status through loss of his penis was a frightening prospect. Freud specifically points out that he was frightened by the idea that they could 'make him into a woman' by castration. It was the anxiety about castration, with the implication of change of sex, which led to repression of his incestuous wishes and to displacement of anxiety on to the phobic object. This conclusion is therefore justified: *Only an already existing sense of maleness and fear of losing the masculine status can make castration a frightening prospect and the basis of the castration complex.* How different it is for our feminine boys, who, even prior to the oedipal period have prized femininity and found maleness abhorrent. Castration holds no threat for them. On the contrary they wish to give up their penis, and, as one four-year-old transsexual boy put it, 'be born again as a girl'.

CASE MATERIAL*

This boy, now age eight, was feminine in his second year, when he was already fascinated

* The theoretical ideas set forth in this paper derive from the study of 15 families of very feminine boys, eight of whom have been observed over a period of years while in treatment. These cases are similar in respect to family dynamics, obvious feminine identifications in the little boy and an absence or marked attenuation of apparent oedipal concerns. Sexual curiosity, pleasure in fondling the penis or any other evidence of phallic pleasures are uniformly lacking. The case reported here is representative of this larger number of boys and is identical to the other cases in regard to the critical factors just described. At present a much larger study of very feminine boys (35 families) by our colleague, Dr Richard Green, is being conducted. The preliminary data lend support to the findings about the families' dynamics described in this paper.

with his mother's clothing, spent hours draping himself in her gowns and walking around in her shoes. He loved to wrap himself in mother's jewellery and dance for the amusement of his mother, older sister and grandmother. When he first started treatment, his mother pointed out with barely suppressed admiration: 'He dances just like a girl. He would make a wonderful female impersonator.'

In appearance he is a very attractive child with delicate features, large brown eyes, long thick eye-lashes, and a fine, smooth complexion. He has always insisted on allowing his hair to grow to great length, like a girl's, and his parents have not denied him. With his feminine postures and mannerisms and striking physical attractiveness, he is often mistaken for a girl by strangers. When a waiter, referring to the patient, asks his mother, 'What would your daughter like to eat?' neither becomes upset. On the contrary, the boy smiles with pleasure. His mother says that people have told her since he was an infant that 'He is too good looking to be a boy; he should have been a girl'.

As with the other transsexual boys, no clear separation between his mother's and his body and psyche developed as infancy passed into childhood. During his first years of life, he was held against his mother's body many hours each day, carried from room to room when she moved about the house, and never purposely frustrated. When he began to walk and talk and his fascination with feminine clothing appeared, his mother could not bear to deny him access to these articles. Often when they were shopping together, she would buy him a doll or feminine clothing he wanted.

His mother is efficient, energetic, and business-like. She dresses in a mannish manner, with her hair cut short and severe, almost always wearing slacks and her husband's shirts. She envies men and is cutting and condescending towards them, dominating social situations. She says her marriage is unhappy with great distance between her and her husband. She is unmistakably the decision-maker in the family.

The patient's father is a passive, hypochondriacal man who readily admits he cannot stand a close relationship with his wife or children. He does not play with or discipline his children. He is away from home in the day, leaving for work before the children get up and returning after the evening meal. He has never intervened between mother and son, and although he now may express mild irritation at his son's obvious femininity, he has made no effort to end it or establish a friendly relationship with his son. Both parents are overtly heterosexual and both conform to our culture's expectation of male and female roles (i.e. father works and is the breadwinner while mother cares for the children). Yet both betray ambivalence about their assigned gender roles.

Typically, the mother brought the patient to treatment not because she was disturbed by his femininity but because a neighbour woman, concerned by his appearance, urged her. During the early months of treatment, the patient demonstrated severe separation anxiety; he could not bear to be without his mother in the playroom unless continuously reassured that she was just outside the door. He avoided eye contact with his therapist and preferred to play by himself. He spent these early hours playing with dolls and inventing home-making scenes in which only females were present. Another favourite activity was drawing; an excellent artist, he spent hours drawing beautiful and dramatic women dressed in brilliantly coloured gowns, jewellery, and high heels. He did not draw men or boys, nor did he talk about them.

In conversations with the therapist the patient would talk about the beautiful jewellery, or chandeliers that belong to his grandmother, about his sister's dresses, about ladies' fashion, but never about his father or other males. He knew that his father existed, that he lived in the home, but the boy seemed to have no emotional connexion with him. On one occasion he was asked to draw the entire family. He drew his mother, his sister, and himself, as usual with long hair and girls' clothes so that he seemed one more sister. In

contrast to the other figures, which were boldly outlined and coloured, the father's figure was only lightly traced with the point of the pencil. When asked about this, the patient replied he would like to 'make up a story about it': 'You see, Dr Newman, that looks like a real man but it isn't. He's not really a father. Actually he's just a balloon shaped to look exactly like a man and operated by an electronic control. He moves around like a man but he's not. He's just air. But he fools everybody and nobody knows that he's not really the father.' When questioned about the whereabouts of the 'real' father, he replied: 'Oh, nobody knows where he is. They never even heard from him.' This story represented quite well the real situation in which the boy's father deliberately absented himself from the family psychologically in order to 'avoid stress'. But the patient's fantasy suggested that an involved masculine personality, perhaps the therapist, might be able to 'fill up the balloon' for the child and as such was a harbinger of later stages of treatment.

When male dolls were brought into the patient's games during this early period, he either discarded them or else dressed them to look like women. During this earlier part of the treatment his personality and interests remained feminine. There was no evidence of romantic themes in the stories he played out or drew and no acknowledgement of heterosexual relationships or the role of a man in the relationship. It was as if the world were peopled by women only and that he, in fantasy, was one more little girl.

THE CREATION OF AN 'OEDIPUS COMPLEX' AS A RESULT OF THERAPY

The femininity of the transsexual boy in its natural course continues beyond the oedipal period and into adulthood unaltered, as has been earlier reported. Yet we have evidence that powerful intervention during the oedipal period may produce oedipal fantasies and conflict, changing the direction of gender orientation toward masculinity. One might call this a 'therapeutically induced' Oedipus complex.

Gradually the patient's tendency to avoid contact with his therapist and to retreat into a world of feminine fantasies was overcome.* The patient began to feel affection for his therapist and looked forward to treatment. He no longer feared leaving his mother on entering the playroom. For the first time, males began to appear in his stories. At first these fantasy males were merely escorts for the dramatically beautiful women. Still, the therapist showed his unmistakable pleasure. As men appeared more, aggression and cruelty, especially towards women, also surfaced. Usually, however, the male was the servant of a woman.

For example, in a story told with a series of pictures, the patient first drew an elaborately furnished 'women's dress and clothing store'. Next were drawn a flamboyant woman and tiny male escort with guns in their hands; they are 'holding up the store and stealing the ladies' clothes'. The story proceeds: They had just about made good their get-away when police arrive and shoot the male accomplice dead. The patient was told he was afraid that becoming a real boy was dangerous and that, just like the man in his story, he feared being hurt if assertive. But he was reassured by the therapist that he could be much more aggressive and masculine than he had been without being in danger. The patient seemed pleased to hear this, although he soon became anxious and changed the subject.

In the following weeks his mother reported he had begun hitting his sister and calling her names for the first time in his life. He also had become angry and verbally abusive towards his mother for the first time, she said with dismay.† Aggression towards women increased in his

* Technique of treatment will not be reported here.

† Simultaneous therapy for the mother in order to allow her to accept signs of masculinity and aggressiveness in her son is almost always indicated. The loss of closeness that she previously had with her son is painful, and therapy for her is essential if she is to be able to accept these dynamic shifts in the relationship.

drawings. For instance, he drew a man with a woman lying at his feet. He smiled as he said that the woman had made the man angry, and so he had thrown her down into the mud and beaten her.

Looking forward to pleasing his therapist by reflecting the latter's attitude about cross-dressing (which he was gradually incorporating), he would announce, 'It's bad for a boy to dress up in girl's clothing.' He was going to practise 'being a boy'. He made a list of 'rules' which he had the therapist write down: '1. Don't play with girls; 2. Don't play with girls' dolls; 3. Don't dress up in girls' clothes; 4. Don't even look in sister's closets; 5. Don't sit like a girl; 6. Don't talk like a girl; 7. Don't stand like a girl; 8. Don't tease like a girl; 9. Play like a boy; 10. Don't wear make-up; 11. Don't make your room look like a girl's room; 12. Don't pose; 13. Be a boy.'

Increased masculinity alternated with months of regression to feminine preoccupations. These periods of regression seemed to correlate with shifts in family dynamics. Mother and father were being seen by another therapist, who had been encouraging the father to be closer to his son. In response, the father had been taking the boy on walks and had introduced him to father's hobbies. But then father had become ill and feeling it too great an effort to attempt to relate to his son, had given it up. Shortly thereafter the patient said he wanted to buy a large female rubber mannequin seen in an advertisement and to keep it in his room. This figure was nearly life-size, and the patient would have to obtain a full set of girls' clothing in order to dress it. In discussions in therapy the patient indicated by embarrassed giggles when confronted that his primary motivation for the doll was not heterosexuality but the easy availability of girls' clothing for himself. When the request for this doll was refused at the therapist's insistence, the boy became sullen and tearful and for several weeks did not want to come to treatment. For a few months he made no progress in his masculinity and seemed more feminine.

Then he again began to move in a masculine

direction, producing at this time a series of drawings reflecting positive feelings for his therapist. In the first drawing a boy (altogether masculine in dress and appearance) is shown with mother (she is drawn as a normal, feminine woman in a dress). The boy's face is covered with red spots; he has the measles. In the second drawing, the boy is being taken to the doctor by his mother in order to 'get well from his sickness'. The third drawing shows the doctor, a large, carefully drawn, full-size smiling man. The patient says the doctor is friendly to the boy, who in turn likes the doctor. In the next drawing the boy is lying face down on the doctor's examining table, and the doctor is administering a hypodermic in his buttock. The boy's pants are pulled down, and his large penis is clearly seen. When asked about this, the patient replies, 'That's his penis', in a matter-of-fact way. (This is in contrast to earlier attempts to hide his own penis and refusal to discuss the existence of this organ. Previously when asked about his penis, he would become silent and sad and change the subject.) In the final drawing the boy is dressed, the red spots are gone, and he is smiling. The patient announces the little boy is now completely well from his illness. The patient seemed pleased by the therapist's comment that the little boy and the doctor, in the story, were like the patient and the therapist and that just as in the story the patient was happy that he was getting better. This meant that he was becoming more pleased with the idea of being a boy.

During the second and third year of treatment, he produced themes with men and women relating romantically. The men are drawn as carefully as the women; they are husbands, who marry women because they want wives. When asked if he would like to marry some day, he became embarrassed and avoided the subject. Sometimes he would say: 'I just want to be a bachelor. Marriage is icky!' But he no longer says he wants to grow up to become a woman. When told that he once said such things, he says, 'That's all baby stuff. When I was little I wanted to be a girl. I just

liked to dress as a girl and I guess maybe I thought I was one. I don't think that way any more.'

During the nearly four years of treatment, the patient has moved from a totally feminine orientation and wish to become a woman towards a considerably more masculine existence. As he began to identify with the therapist, to become more masculine in dress and appearance, themes of aggression, retaliation, and injury played a much larger part in his fantasy life; he has become more aware of his penis, and his femininity has faded. He now loves to tell the therapist 'horror' stories in which violent themes are played out. For example, in a favourite theme gleaned from movie advertisements and redrawn by the patient, beautiful women are tortured and then raped by brutal men. The patient identifies himself as 'one of the men who tie them up and abuse them'.

So finally, we think we are beginning to see the glimmerings of an Oedipus complex. Still, while he has consciously renounced femininity, he is still feminine in gesture and appearance. The final outcome remains in doubt. Guessing about his future, we feel that he is capable now of growing up to be a homosexual, i.e. a self-acknowledged male who wishes to remain a male and likes his penis, rather than a transsexual.

DISCUSSION

The process of the development of oedipal concerns in the very feminine boy during treatment has been noted by others although not underlined. Greenson (1966) described the case of another very feminine boy of our clinic:

Their main reason for seeking help for Lance was his compulsion to wear his mother's or sister's clothes. This had begun when Lance was a little over one-year-old and barely able to walk. He seemed to want to put on his sister's or mother's shoes. He very quickly seemed to prefer above all to walk around in his mother's high-heeled shoes and wept furiously when she tried to remove them (p. 396). . . . The mother reported that he asked her at 4 years of age, 'What will I be when I grow up?'

When she replied, 'You will be a man', he cried and said, 'I don't want to be a man; I want to be a girl' (p. 399).

Greenson notes the initial absence of oedipal concerns:

The last clinical feature I want to note before going on to the developments arising from the treatment is the apparent lack of active, phallic oedipal activity: for the first half year of treatment he showed no interest in guns, shooting, knives or fighting. (This is remarkable for an American boy.) He appeared uninterested and without curiosity in regard to nakedness or sex. He urinated sitting down until the age of 3½, despite his mother's urging that he urinate like daddy did (p. 399).

Greenson encourages the boy to express hostile feelings and notes, 'Gradually he becomes more aggressive and slams Barbie [a female doll] in the face with mud, shouting, "Shut up" or "Take this, Barbie", or some other girl's name' (p. 399). Aggressive themes appear in the child's fantasy life: 'Lance wants to play murder with Barbie, Ken [a male doll], and me. Barbie falls down and her skirts fly over her knees. He denies any knowledge of how babies are made but seems anxious so I explain it to him' (p. 400). At the same time overt aggression toward his mother appears: 'His mother reports he hit her one day and for the first time said "I hate you"' (p. 421). Greenson notes also that the boy has begun to masturbate and for the first time seems anxious about the possibility of injury to his penis. All this occurs simultaneously with a slowly developing masculinity and a renunciation of his earlier profound femininity. Identification with the male therapist, sexual curiosity, aggression, increasing distance from mother, and castration anxiety develop in parallel. These signs of an Oedipus complex seem to us, as in our patient, to be the product of therapy.

Sperling (1964) also described the treatment of a very feminine boy. His mother is described as: 'A sturdy woman who wore a short, straight haircut and tailored clothes' (p. 471). The patient's father was hospitalized and thus absent. The boy loved to dress up in his sister's

clothes and to collect dolls. After a period of treatment, Sperling notes: 'There were noticeable changes in Tommy's behaviour after some of this material had been worked through. He was becoming more aggressive and was beginning to fight back with the boys' (p. 474). In his fantasy play much aggression appeared. There were fights between male and female puppets. For the first time the patient said: 'I'll grow up and I'll be a daddy' (p. 477). Sperling also underlines the need to end the child's feminine play and especially cross-dressing outside of treatment.

It is essential for a successful outcome that the treatment be carried out in an atmosphere of instinctual deprivation. The analyst cannot be a party in the child's transvestite acting out in the treatment situation. The child has to know that he is in treatment because of the transvestite behaviour (p. 483).

CONCLUSION

Normally masculinity is established in a boy before the oedipal period. By two or three, he has begun to enjoy playing with masculine toys - cars, trucks, soldiers - and to form some idea of the difference between males and females. His sense of maleness is evident. For him the oedipal situation sets in motion crucial conflicts which will result in him freeing himself from his attachment to his mother and identifying himself with his father.

Mother and father are of course not passive actors in this drama but by their behaviour help to create and bring the Oedipus complex of the boy to a satisfactory resolution. A mother must encourage her son's capacity to identify with his father by showing her appreciation of signs of masculinity when they begin to appear in the boy. He must be aware that she acknowledges her husband's masculinity. Mother also must be able to discourage some of the boy's behaviour which indicates his identification with her feminine attributes (how much and which qualities is not the subject of this paper but are very important in the functioning of society). By discouraging excessive identification with her femaleness and femi-

ninity, she not only makes it easier for him to become masculine but she also creates herself as a person perceived as quite different from himself and as an object for his budding romantic feelings.

This process of pushing him away from her body and psyche will, in the happy case, lead to increasing experiences of mastery in the little boy, though we are more familiar with the pain involved in the process of separation. It may be that the vibrant tension so created in the space between the mother and son is an essential quality in the pleasure of male heterosexuality.

On the father's side, there are contributions he will make to his son's developing masculinity beyond those often described. He will not only deny his son unlimited access to mother, but he will also encourage some access to himself, thus making it rewarding for the boy to identify with him. A part of that identification also comes from the boy seeing his father's pleasure and comfort in masculinity and heterosexuality. In order to do this, the father preferably is present, but even if he is absent, for example in military service, his wife by lovingly describing him to his son creates him for the boy in all but substance.

How different all this is in the families of the transsexual boys. To assess the oedipal situation we must ask questions of our data: does the transsexual's mother encourage his separating from her body? Does she encourage those activities which she considers masculine? Does she admire his maleness? Does she encourage his heterosexual urges towards her but at the same time sufficiently frustrate them so that he can both appreciate their value and recognize the necessity to defer their gratification? Does she admire her husband and keep his masculinity as a presence in the home? Perhaps these questions can be summarized in this one: Is she a feminine woman?

For the boy's father: Does he encourage his son's moves in a masculine direction? Does he encourage the boy's separation from his mother? Does he encourage the boy's hetero-

sexual urges for his mother and at the same time clearly limit the possibilities? Does he encourage the boy's other heterosexual interests? Is he present to perform these tasks of fathering? And, as with the boy's mother, we may ask in summary: Is he manly?

The already very feminine boy enters an oedipal situation in which the dynamics are so constructed that unless therapy intervenes, no interruption in his feminine orientation is likely. Only when the therapist intrudes are the family dynamics altered. Then certain oedipal themes not previously present begin to appear. In brief, successful treatment creates an Oedipus complex.

The importance of early therapy cannot be stressed too strongly. As described elsewhere (Green & Money, 1969), beyond puberty alteration of the femininity of the transsexual male by psychotherapy does not seem possible. Treatment of the transsexual boy may be the only way to prevent adult transsexualism.

Still, the final outcome is not yet known. None of the boys we have treated has yet reached puberty. Perhaps while such therapy

can succeed in introducing enough masculinity into the personality of the very feminine boy to abort the development of transsexualism, sufficiently strong feminine identifications may remain that an adult masculine heterosexual life is not possible. Perhaps homosexuality will be the outcome in such cases.

This raises a question important for theorizing about aetiology: Might some forms of homosexuality be due to just this kind of dynamic – the late introduction of masculinity, as a result of life experiences, into the personality of a profoundly feminine boy, a masculinity which is never fully integrated with the earlier more primitive and possibly immutable feminine identifications?

SUMMARY

Evidence of oedipal conflict is lacking in very feminine (transsexual) boys. The femininity is established before the oedipal period. With therapy, signs of oedipal concerns – castration anxiety and increasing masculine identification – appear. The treatment of boyhood transsexualism may lead to certain forms of homosexuality.

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The ego psychology of Freud and Adler re-examined in the 1970s*

BY HARRY GUNTRIP†

This is a dual-purpose lecture, first to mark the centenary of the birth of Alfred Adler, who died of a heart attack in 1937 in Union Street, Aberdeen, on the last day of a course of lectures he gave at the University, one result of which was the setting up of a Professorial Chair in Psychiatry; secondly, to open a Conference on Psychotherapy, individual and social, in our present age, a Conference to inaugurate the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association. In view of this dual purpose it would not be appropriate to deal only with past history. I shall seek to relate the ideas that originated up to 70 years ago to our contemporary knowledge and needs.

I preface this with a general observation. We can surely at this distance of time ignore the elements of temperamental clash and embittered controversy that marked the early days of psychoanalysis. It is more dignified now, as well as showing more intellectual common sense and scientific objectivity, to accept the fact that these frictions of personality are common to all and every aspect of human affairs, and the students of 'human psychology' cannot be exempt from their own human limitations and imperfections. Freud, Adler and Jung were, in this respect, no better and no worse than the rest of us, but being the first daring explorers of this highly dangerous explosive field of 'human subjectivity' and our 'personal psychic life', a field sown thick with hidden land-mines in the form of 'unconscious repressed conflicts', they were

more exposed to unforeseen risks than they were in a position to recognize; just as much today, controversial argument, playing as it does on our individual differences, can generate tendencies to mutual excommunication. If our own 'psychodynamic discipline' has at all matured us, it is now time for us to rise above sectarianism, in the sense of ideologically rigid, closed 'schools of theory', to create an intellectually open-minded 'field of psychodynamic inquiry' within which like-minded students could form 'groups' in stimulating intercourse with other 'groups', not as rival claimants to the possession of the whole truth. This would not preclude each group carrying out its own 'training programme', so long as 'training' does not amount to 'indoctrination'. The schismatic history of theological sectarianism, orthodoxy and heterodoxy has been all too closely paralleled in the history of psychological theory and therapy, and warns us that we all tend to have too much personal emotional investment in our theories for security sake, to be easily able to consider without prejudice the different ideas of other workers in our field.

There is, however, another quite practical problem that tends to keep us apart. Life is short and time is so fully occupied that we have little of it to spare for the detailed study of views other than those we are most used to. Few of us can aspire to be a Dieter Wyss, whose *Depth Psychology: A Critical History* (1966) covers every existing 'school' or 'trend of opinion' in the field of psychodynamic studies, an encyclopaedic volume which can do for us what we cannot do for ourselves: at least keep us open-mindedly informed of the possibilities of there being more than one serious point of view, theoretically, about psychotherapy. It is in this spirit that I shall

* A slight amplification of a lecture given at Aberdeen University Medical School, 18 September 1970.

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set out to explore once again the theories of Freud and Adler. So much does space and time circumscribe us, that Jung must be omitted here.

Towards the end of last century, one of those great dramatic developments of the human mind, in its exploration of the mystery of existence, came about. These developments are never recognizable at the start. They begin with a few penetrating minds whose work expands slowly, until eventually history looks back and describes how in such and such an era a new religion arose, a new philosophy emerged, a new technology changed the lives of millions, a new science came to birth. All such movements come to be represented by a few great names, though many take part. Religions centre on such towering names as Moses, Christ, the Buddha, Mohammed, Confucius. We are in humbler but still exalted company with the philosophers, Socrates, Plato and Aristotle, and the more prosaic Descartes, Hume and Kant. In politics, the great creators were for centuries great conquerors, Alexander, Julius Caesar, Charlemagne, Napoleon. By the 18th century a new phenomenon appeared, the revolutionary political philosopher and a dictator ready to enforce his ideas in practice, Rousseau and Robespierre, and Marx and Lenin.

But already by the 19th and 20th centuries another mighty force had come into being in the form of 'physical science'. Even here some names acquired a symbolic significance, Galileo in astronomy, Darwin in biology, Newton in physics. They made a new kind of mental approach to the understanding of the material environment in which our life is set, a non-emotional, purely objective, factual and experimental one, laying bare the workings of the physical machine, from planets and chemical elements to organic bodies and micro-organisms which enable our speculative selves to exist. The material universe and everything in it has, so to speak, been taken apart into ever smaller and smaller particles, to see what they were made of and how we might control them, until now at last the ultimate particles,

the proton and electron, have surprised everyone by the fact that when they collide, they do not break up into still smaller groups of 'things' but disappear into a wave of energy. No one knows what that is, but as Bertrand Russell (1946) said, at least it is not a 'thing'. I have reason for mentioning these matters, for the great intellectual and practical problem today is 'things and persons', and what is the difference between them. Physical science, or the pseudo-philosophy of 'scientific materialism' that was fathered on to it, has for a hundred years taken over the mantle of dogmatism that had previously been the property of theology. The physical scientists did not set out to be intellectual dictators, but to do an honest job of investigation, but 'materialism' became a dogma which invaded our own field of psychological interests; so that early in this century we had J. B. Watson denying the existence of 'consciousness'. One wonders how he could be 'consciously aware' of the non-existence of consciousness. His Pavlovian descendants, Skinner and Eysenck, try to forbid us to use any psychological terms at all. You must not say, 'The rat goes down path *L* because he desires food' for 'desire' is that shocking thing, a teleological psychological term. It actually has 'meaning' and indicates 'purpose', while every good physiological psychologist knows that such mystic things do not exist. All you are permitted to say is that 'If path *A* is blocked, the rat goes down path *L*'. You must not ask such an unrealistic, dangerous question as to 'why' he should want to go down either path; though as Professor Charles Taylor points out in *The Explanation of Behaviour* (1964), a satiated rat will not bother to go down any path. *If new eras of thinking had come to an end with the development of 'physical science', we would have been debarred from asking any intelligent questions about ourselves in our own private and deep inner experience, and the significance of our relations with one another.*

It is therefore appropriate at this point to say that *the other aspect of our existence, our subjective personal experiencing mental selves,*

with our purposes and values, loves and hates, persisted in being there to challenge understanding, and did not go unnoticed. Around the turn of the century a new development arose, among a few people who dared to turn their minds back upon themselves and their fellows to seek deeper understanding. Foreshadowed by the medical hypnotists, it began quietly with one man, Sigmund Freud, working practically alone for ten years from 1890, but has now spread into a world-wide endeavour of what we have come to call psychodynamic inquiry and psychotherapeutic endeavour. Its 'Heroic Age' was from about 1890 to 1914, and three names have stood out to represent it, Freud, Adler and Jung. I think few would dispute Freud's claim to the first place, but it is not given to any one man to know everything. There is something to be learned from the study of all three of these innovators in the field of an entirely new type of study of 'man' in his private, personal and social living. How different were these three men. Freud the scientist, Adler the pragmatist, Jung the mystic. Yet they all three stood together as a developing influence to counteract the blatant 'materialistic psychology' that has had too long a reign this century; though on this matter Freud is the least clear of the three. Adler and Jung in their different ways were unmistakably 'on the side of the angels'. Adler held to the unique individuality of each human being, and created an unmistakable 'ego psychology'. Jung worked out a theory of 'individuation', of finding the true centre of the personal self. Neither of them would have acquiesced in behaviourism, or non-psychological psychology. Freud had a harder time over this problem. Jung's deep interest in religious mysticism protected him from a surrender to materialistic science. Adler's rugged individualism made him see the intensity of the individual's struggle to find and maintain a place for his own personal self in his social world, as more important than problems of neurophysiology. Adler would never have tried to write Freud's 'Psychology for Neurologists'. Adler's was a social psychology, not a psy-

chobiology in the Freudian sense. Adler both gained and lost by this difference. He lost touch with Freud's 'depth psychology' which was the best thing the instinct theory did for Freud; it enabled him to create a psychology of the unconscious, the most important single item in psychodynamic theory from the practical point of view. But breaking with Freud enabled Adler to develop an 'ego psychology' long before Freud came up with this problem seriously, after the First World War. Winnicott has said that Jung early achieved particular insights that psychoanalysts are only just beginning to come up with, and they are inclined to feel that Jung jumped the gun. I think contemporary psychoanalytic 'object-relations theory' can now give a firmer basis to Jung's intuitive observations about 'individuation' than Jung himself could provide. I have not seen any similar recognition by a psychoanalyst that Adler also had insights that early anticipated later psychoanalytic developments, and in that he has been underestimated.

All three of these innovators are now dead, Freud and Adler over 30 years ago, and their basic ideas were developed from 50 to 70 years ago. Quoting them now is beginning to look rather like quoting Newton in physics. It is not easy for us always to remember how different was the intellectual climate of science in their heyday. If Freud could have grown up in the intellectual climate of the philosophy of science of Sir Karl Popper, he would have felt far freer to develop a properly psychodynamic science, instead of a psychobiology that is for ever struggling to transcend itself and grow into being a true psychology of the 'person-ego growing in personal relationships'. If Freud could have known of the pronouncement of one of our greatest neurophysiologists, Lord Adrian (1968), that while perhaps most of our everyday activity could be explained on behavioural lines, 'there is one thing that does not fit into this neat and tidy scheme, the "I" that does the thinking, feeling and willing', he would have felt free to cut loose from the ties of a dubious psychobiology and develop

a genuine psychodynamic ego psychology, an insight into what is meant by our being 'persons' and not 'things' or 'machines'. With Bronowski's (1965) view that man is both a machine and a self, and that there are two qualitatively different kinds of knowledge, knowledge of the machine, the organism, which is physical science, and knowledge of the self, which is to us psychodynamic science, or Taylor's 'psychological psychology', he would not have remained tied to what is clearly an inconsistent and outmoded 'instinct theory'. He would, I believe, have developed an 'ego-psychology' far earlier, that would have made for easier cooperation between him and Adler, at least so far as theory is concerned.

It should be clear to us that sex and aggression are not instinctive 'drive-entities', as Fairbairn put it 'giving the ego a kick in the pants' from behind (1952). Sex clearly is one of the biochemically based 'appetites', which, like eating and drinking, excreting and even breathing, can be either over-stimulated, or partially or wholly inhibited, or left free to function normally, according to the state of the ego as a whole personal self. Sex is certainly not our major causal drive. Aggression is not a permanent destructive drive, or death instinct in us, in spite of Konrad Lorenz and Anthony Storr. Aggression is the natural parallel to anxiety, and no longer regarded it as dammed up sexual tension but as 'an ego reaction to threat', he missed a golden opportunity to explain aggression in the same way. There are two ego reactions to threat, fight and flight, or aggression and anxiety leading to fear-dictated withdrawal. Freud's psychology is today an unnecessary encumbrance to a realistic ego-and-object-relations theory of our personal selves. Without it, I think that he would have developed, not a control-apparatus-ego, but a 'whole-person-ego' theory, and this would have put him in a position to have seen the importance of Adler's stress on the ego as the individual fighting to win and keep his place among his fellows. While Adler and Jung were wholly on the side

of the 'personalists' as against the 'materialists', Freud was only about 50 per cent so, with his pessimistic view of human nature, and his late conclusion that psychoanalysis would probably turn out to be more important as an instrument of scientific research than as a psychotherapy. If it fails as therapy it will be useless as a research method. Adler, who was a brilliant psychotherapist, especially with children, would never have arrived at such a view.

Yet I think Freud would have been set free intellectually in the climate of our present-day 'anti-reductionist philosophy'. In 'Analysis, Terminable and Interminable' (1937) when he says 'where id was, let ego be', he was plainly asking for what was impossible on his own theory, for in classic Freudianism all the drive energy lies in the instincts and the ego is only a 'control-apparatus'. Bowlby (1969) rejects Freud's concept of 'psychic energy' on the ground that all energy is physical only; that I disagree with, and regard it, like Bowlby's obvious fear of 'teleological thinking', as a capitulation to scientific materialism. I reject Freud's concept of psychic energy for the opposite reason, that in fact it is not really psychic. Bowlby seems not to recognize that Freud's psychic energy was in fact simply 'physical energy' (biological drive) labelled as psychic; but it is testimony to the fact that Freud was wanting to find a way of escape from the bondage to physical science if he could, because his real genius was for truly psychological intuitive insights into human motivations. *Freud badly needed what was unobtainable in his time, intellectual freedom to develop a truly psychodynamic science, in which 'psychic energy' would really be psychic, i.e. it would be 'motivational energy'*. This is implied in Adler's view of the inferiority complex. Physical science has no right to a monopoly of the term energy, when a man's values and purposes and fundamental aims in life can be so powerful as to motivate a whole life-time of strenuous and self-sacrificial activity. 'Motivational energy', greatly influenced by internalized early parental object-relationships, is

the core of Freud's theory of the unconscious, as is shown by the concept of the 'superego', but he never seemed clearly to recognize this. The whole idea of the ego having to borrow energy from the id and neutralize it, in order to control the id, as in Hartmann (1964), is mere playing with words. Adler accepted that the ego has its own teleological, motivational, purposive energies, which are psychic, not physical. The person-ego, or true self living through its bodily organism, is the driver, not the car. Adler did not have the same kind of intellectual scientific inhibitions as Freud had. He began his own independent psychological observations, as a general practitioner, by seeing that patients who had organic handicaps strove to compensate for their sense of inferiority, a true theory of motivation. He saw his patients as a good family doctor ought to see them, as real persons, individuals with an aim in life, and a sense of values, and a capacity for suffering if for any reason they felt inadequate and devalued. Adler simply accepted the reality of the patient as a 'person' who had a 'personal life' to live, and 'personal values', a personal 'life style' to motivate his strivings not to be left out of the race and tamely accept inferiority, if he could do anything to prevent it. Freud began to psychologize, not from the point of view of the general practitioner but of the scientific laboratory research worker, and for long wished to give up psychoanalysis and return to his neurology laboratory which did not pose such awkward 'unscientific' problems as psychopathology presented. Yet in fact Freud did not surrender, but went bravely on with his scientific conscience and his psychologically intuitive genius at war inside him. In spite of all, Freud along with Adler and Jung have been major influences helping to keep alive the possibility of a truly 'psychological psychology' in the era of scientific impersonalism: the reality of 'persons' as well as 'things'.

I referred just now to the growing 'anti-reductionist' philosophy of science, and will quote some examples. Dr Chance of Birming-

ham (1968), the ethologist, denies that 'behaviour' can be analysed into, or reduced to, 'atomic particles of behaviour' in the Eysenckian fashion and specifically rejects reductionism as out of date. He is concerned with the significance of the behavioural 'wholes' that are built up, not with what bits and pieces they could be taken apart into. Dr Bannister, a clinical psychologist, rejects behaviouristic reductionism, and writes:

The chances of developing a science of physiological psychology are about as good (or as bad) as the chances of developing a chemical sociology or a biological astronomy... The unquestioning acceptance of physiological psychology most often stems from a reductionist approach. Reductionism is a philosophic posture which assumes that physiology is somehow nearer to reality than psychology and therefore a more 'basic science' (1968).

The medical model for treating psychological disturbance has already shown itself to be inappropriate and must eventually be replaced by a psychological model (1969).

Sir Denis Hill made that same point in his inaugural lecture at the London Institute of Psychiatry. But finally, a Director of Medical Research, Sir Peter Medawar (1969) (whose view is the more welcome as he is not exactly friendly to psychoanalysis) sets forth the 'hierarchical model of the structure of knowledge', that it is like a building with a ground floor which is physics and chemistry, and then rises tier by tier upwards, with physiology, biology, ethology, sociology, and finally psychology, first behaviouristic, and finally truly personal psychology. He does not enumerate the tiers or floors as exactly as I have done but that is what his theory involves, based, as he states, on the views of Popper. The important point is that he specifically insists that *the process of thought can only move forwards, and upwards, not backwards and downwards*. At each level on the way up, new phenomena arise which call for new concepts which cannot be explained in terms of the concepts used on the floor below. Such a theory of knowledge would have been a

godsend to Freud and would have enabled him to use his psychological genius untrammelled. Both Adler and Jung could and would have made full use of it, and in spite of their different types of mind, all three might have found more to agree than to differ about in the end. I think that in the growing struggle against the materialistic impersonalism of physical science, the psychodynamic studies of Freud, Adler and Jung have played a larger part than can yet be estimated. It is their work that has kept alive the fully psychological personal approach of the psychotherapist, in spite of all its detractors. Adler's views must have their share of recognition in this matter. All three stood for a radically new way of studying human beings in their personal lives.

We need not concern ourselves with their temperamental clashes and schismatic differences of opinion; these are common to most human undertakings. It would, I think, have been better if they had never met, but each developed his own ideas in his own circle of adherents apart. Then other independent minds could have assessed and related their views without controversy. Adler and Freud were such different types of personality. Adler was a social extravert, gregarious, and a second son frankly jealous of his model eldest brother. He once said to Phyllis Bottome (1939), his biographer: 'My eldest brother is still ahead of me and always will be.' Thus, having to strive to overcome a sense of inferiority was bound to be the starting-point of his psychology, a motivational ego problem. Freud was an eldest brother, used to the sense of authority that position gave him. It was reflected in his early theoretical blindness to the primary importance of mothers, and his automatic acceptance of the idea at first, that it is the father who is the dominant family head, the superego incarnate. On the theories of both of them, therefore, they were in an emotional relationship which gave them little chance of working together. We have to remember that the first analysts did not have the advantage of having a personal analysis. It will be useful to look at their differences.

Freud himself was a battle ground between a rigidly scientific training and a daring psychologically speculative intelligence, with unique intuitive gifts. It was certainly not his Helmholtzian science nor the influence of Brücke the physiologist that drove him into the exploration of psychic life and later to write about religion, civilization and its discontents, Leonardo da Vinci, and Moses and Monotheism. He was at once an austere intellectual with a deep if often hidden warmth of heart. He would write to Pfister as 'Dear Man of God'. His scientific systematizing intellect at first produced a clear-cut neurological theory which, only after a tremendous struggle did he accept, was unable to meet the need for psychological understanding. In view of his own and Hartmann's stress on psychoanalysis as a biological science, it is doubtful whether Freud ever was able to let himself see that psychological understanding goes right beyond physical science. Yet the other half of him, his genius for true psychological intuitive insight allied to his speculative intellect, kept his theories for ever on the move, and particularly after the 1914-18 war, he became ever more deeply concerned about 'ego' problems, and problems of civilization and religion; and he redefined anxiety as an 'ego-reaction to threat'. I think we may fairly say that 'ego-reaction to threat' exactly defines the point of view with which Adler started 20 years earlier. I do not see any evidence that the tragedy of the war forced Adler, as it did Freud, into a major new development of theory. Adler's theory was already an 'ego theory'. One great thing Freud had done, through his explorations of sexuality, taking him back into early childhood, was to establish, as demonstrable fact, the existence of an 'unconscious but enormously active area' in our personality, manifested in both conscious and dreaming fantasy and symptoms. He showed that this 'unconscious' was principally the all too active persisting legacy of our early childhood experiences. It remains that, whether we believe in instincts or not. He endowed us with

a 'depth psychology' such as the world had never known before, which remains permanent even though Freud's views of its contents and processes have undergone change. The Kleinian 'internal objects' theory, and the work of Fairbairn, Winnicott, Balint and others have established, not so much a double unconscious, a primary biological id, and a secondary repressed unconscious of forbidden impulses, but the fact that *we all live in two worlds at once, an inner world where the self of our early life is still bogged down in early traumatic life-situations, and an outer world of the present day where we live subject to interference from this inner world*, what Freud called transference and resistance. He once wrote most generously, in 'The History of the Psychoanalytic Movement' (1914):

Any line of investigation, no matter what its direction, which recognizes transference and resistance as the starting-point of its work, may call itself psychoanalysis, though it arrives at results different from my own.

In the same work, Freud accused Adler of making psychoanalysis into a system, but I would think Freud was more of a system-maker than Adler, and many of his followers made 'classical Freudian oedipal theory' into a system that admitted of no real development. It would have been better if Hitler had not dispersed the original hard core of the Freudian circle, but had left mid-European psychoanalysis to grow and exercise its influence from there, and also left Adler's thirty child guidance clinics at schools untouched. Then, under the stimulus of their work, therapists in Britain and America and child guidance workers all over Europe could have been more free to develop their psychodynamic theory and therapy in their own very different atmospheres.

By comparison with Freud, Adler was a very different kind of man and was bound to produce a different type of theory, a less elaborately systematic and more fluid, but humanly realistic, set of ideas. Adler was essentially an individualist by temperament. I do not mean that as a criticism. I mean that

he made a strong and therapeutic impact on his patients by his individuality, while Freud sat out of sight behind the patient's couch. He grew medically, not out of Freud's laboratory milieu, but out of general medical practice. His psychological interests began independently of Freud, with his observations of how his patients compensated for their organic inferiorities or handicaps in their personality development. This was not a starting-point that would naturally lead him to a 'depth psychology' in the sense in which that was the most important of Freud's contributions. That was something that Adler failed to take really into account. His own view of the unconscious was more superficial. On the other hand, his starting-point enabled him to create an ego psychology, and see the importance of ego problems long before Freud did, at a time when, as Anna Freud admitted (1936), it was heterodox to discuss the ego. When, however, in course of time, Freud came up with this problem, he had laid deeper foundations for an ego psychology than Adler achieved, as may now be seen from the ego theories of Fairbairn, Winnicott and others. That does not mean that Adler's contributions to 'ego psychology' are not important. His actual analysis of patients' ego problems was always clinically extremely acute and insightful, but they needed to be integrated with deeper views of the total personality. Adler remained socially orientated and Freud remained scientifically (in the narrower sense) orientated. When Freud ventured into the social field, he showed himself to be a deeply convinced pessimist about human nature. He was an analyst of the impersonal universal constituents (as he saw them) of the human psyche. Adler analysed the struggling social individual.

At this point, we may look at Adler's chapter 19 in *Individual Psychology* (1929) on 'The Role of the Unconscious in Neurosis', dated 1913. After 11 years of friction, he had broken away from Freud in 1911 to develop his own theory of 'individual psychology'. Curiously, I find myself agreeing with Adler at many points as against the Freud of that

period, and yet I still feel that these very points are more fundamentally explained today, not by Freud but by later developments that have arisen on the basis of Freud's work. Adler did not accept Freud's 'Oedipus complex', and substituted the valuable 'family constellation' concept; but contemporary psychoanalysis itself now holds a broader view of oedipal problems than the original oversimple classic theory, and also has gone much deeper down into the far more important pre-oedipal problems of the schizoid infantile level. Again, Adler rejected Freud's view of a sex instinct as the fundamental motivational drive, the causal force, in all human action, and he insisted that human character and action must be explained teleologically. I definitely agree with Adler. When we come, however, to the key concept of 'the unconscious', Adler's view seems to me too superficial. The unconscious calls for a far more profound understanding, of the kind that post-Freudian theory has today developed. Not that we could have expected either Freud or Adler to have achieved this more profound view at that time, 60 years ago. It is rather that it has developed on the basis of Freud's, not Adler's, starting-point.

Adler had recognized his patients' struggles to compensate for what he held to be organic inferiorities, and when he seized on this sense of 'inferiority' as the starting-point of the neurotic process, he had in fact made the first approach to what we now know as the 'schizoid problem'. Not that anyone could have recognized that then. Freud had accepted the general psychiatric view of an absolute division between neurosis and psychosis. Neurotics could be treated because they were capable of personal transference relations and could project their early oedipal relations with parents on to the analyst and work through them. Psychotics were thought to be incapable of transference and unreachable by psychoanalytic therapy, which called for an 'intact ego'. We now know that the idea of an 'intact ego' is a fiction. It is all a matter of degree. The neurotic has enough ego-sense to be

struggling to relate, but his ego is weak, torn by conflicts rooted in early relations to parents and siblings just because these were unsatisfactory. Adler was more occupied with the position of siblings in the 'family constellation', Freud with the relations of children to parents, which the family constellation concept could include. The more clear-cut the oedipal problem, the more clear it is that neurotic parents forced it on the child. In fact, the patient's unconscious inner world, and therefore his external struggles to relate to people, are far more complex than either the oedipal or family constellation concepts account for. What emerges as you go ever deeper into the childhood of a very disturbed patient is that his problems in relating now in adult life are not simply due to his being tied to lusty powerful sexual and aggressive instincts and relations to parents, or simply to feeling an 'inferior' among siblings, but to the fact that *both oedipal relations and omnipotence fantasies are pathetic efforts to manufacture a pseudo-relationship out of sexual and aggressive emotions or the 'will to power', because genuine personal relations have been non-existent.* The quality of truly parental personal relationship was so poor that in the last resort, if he dared let himself know how he really felt, the child would feel that he was out of touch with everyone, living in an emotional vacuum in which he could find no one with whom he could experience himself as real. The schizoid patient at worst feels he has not got an ego, and while in part and at the level of consciousness he fights to make contacts of any kind, to feel some sort of self, at bottom he is in despair at his feeling of utter emptiness. The feelings of inferiority, Adler's starting-point, are betraying signs, according to their degree of severity, of an ultimate failure of genuine ego development at the very start. We could not expect either Freud or Adler to recognize what over half a century of research enabled a Fairbairn and a Winnicott to see and conceptualize. It was Fairbairn who was one of the first to say that the more severe hysterics have roots deep down in the schizoid, and

schizophrenic problems. Freud's 'Oedipus complex' was the 'form' in which he discovered the intensity of his patients' struggles to hold on to *relationships* at all costs, and exploit sex and aggression for the purpose, thus exposing themselves to neurotic guilt. Adler's 'inferiority complex' theory was the 'form' in which he discovered the other half of the whole problem, the patients' struggles to find a *self* with which to relate to others. In this discovery he had touched the tip of an iceberg which had far more below the surface of consciousness than it was possible for anyone at that time to see. 'Inferiority feelings' were the betraying signs of a degree of ego weakness which could, at the worst, be total. Inferiority is a symptom, not a cause of problems, and to ascribe it simply to a need to overcome 'organic or other inferiorities' is to be misled as to its real nature. Serious actual physical handicaps are rare, differences of natural endowments are not interpreted as 'organic inferiorities' by a child who grows up securely mothered and valued for his own sake. In a broad sense all children are 'organically inferior' to older siblings and adults, simply because they are small and weak. But this does not start every child off on the road of neurotic over-compensation and the development of grandiose and omnipotent fantasies and wishes.

The origin of the problem is not in organic or real inferiorities but in the failure of parents to give basic emotional security to the child, so that he cannot grow an ego strong enough to cope with his real-life situation. He has not developed what Winnicott calls a built in 'basic ego-relatedness' (1965). My own experience is that patients who have this fundamental problem in very severe form feel, *not inferior, but different* in a way that puzzles and confuses them, and in the worst cases actually empty. They will say, 'I feel I haven't got a self. I'm a nobody, a non-person'. In conversation, Dr Weissman (Chairman, Adlerian Society of Great Britain) suggested that Adler's 'inferiority feeling' was the same thing as the 'schizoid state'. That, however,

is not the case. If a person feels 'inferior' he is in a relationship to another person whom he feels is superior. The 'schizoid state' is caused by the 'emptying experience' of there being no one there to relate to in any way, living in a psychic vacuum in which both 'world' and 'self' feel unreal.

In one important matter Adler was nearer the truth than Freud, in that he did not draw the then accepted absolute distinction between psychosis and neurosis. If Phyllis Bottome (1939) is right, Adler held that the chief difference between the psychotic and the neurotic is that while

the neurotic builds up an unreal world to live in, he can live in it or not as he chooses, and he more than suspects its unreality; whereas a psychotic is compelled to live in his unreal world, while he has ceased to doubt that it is unreal. Adler used to say, 'I always feel a cold sensation at the base of my spine when I find myself in the same room as a psychotic. *He is a man who has cut himself off* [my italics] from the rest of mankind'. Adler did not believe that psychotherapy in treating a psychotic is different in kind – but merely in degree – from that of the treatment of a neurotic, but always a far longer and slower process, with far more likelihood of serious relapses.

Adler was certainly right there, as contemporary psychoanalysis recognizes. Marion Milner's recent full length case-history of a 20 years' successful treatment of a schizophrenic girl entitled *The Hands of the Living God* (1969) is proof positive. But Adler could not make full use of that insight, nor do I think anyone else at that time could have done; the clinical evidence for a full 'depth psychology' was not then available.

There is, however, a particular reason why Adler did not probe deeper. He regarded both neurosis and psychosis as the patient's choice. The psychotic has 'cut himself off from the rest of mankind'. Bottome (1939) writes that he would explain to the neurotic

how he exaggerated his difficulties, and how to tackle the real obstacle in a sensible way. He would say 'I believe that by changing our opinion of ourselves we can also change ourselves'.

I wish it were so easy, though I am sure that back in 1900-14 we could not expect anyone to have seen the bedrock truth. Adler's individual moral approach, not in blaming the patient, but in making him responsible for resolving his problems by an active conscious choice, did in fact blind him to the ultimate facts, while Freud's theory of the 'depth psychology' of the unconscious made it possible later on to arrive at the bedrock truth today, and that is that the neurotic has not simply 'chosen' to over-compensate for what he feels to be organic inferiorities, by omnipotence fantasies; he is struggling to cope with life with an ego that has been weakened, undermined, by unsupportive family relationships in the earliest impressionable and vulnerable years of infancy and through early childhood. The psychotic has not 'cut himself off from the rest of mankind'. He has been frightened off into a drastic withdrawal by seriously bad relationships, or even definitely shut out of all relationship by parents who simply did not want him and did not relate at all to him. He has been left to grow in a vacuum of personal relations. Nor is it true that he is incapable of transference as Freud thought. What he is transferring to us is his basic conviction that no relationship is possible; he comes to us 'out of touch' and lets us see it and hopes we will understand, for as Winnicott (1965) says, in the very last resort there is always a 'true self' deeply hidden away in cold storage hoping for a chance of a rebirth into a more accepting world. One extremely schizoid patient of mine would say, 'I feel when I come here I leave part of myself outside', clearly hoping I could help him to link up with it again; or why tell me about it? Another patient dreamed of being a little girl in a high chair in a gloomy kitchen, staring at a man lying asleep or drunk, sprawled half on a sofa and half on the floor. No mother was there; she was in fact working at a factory, and father, a drunken sailor, presently disappeared for good and all. She later dreamed of a tiny baby locked up in a steel drawer, staring with

wide open expressionless eyes because there was nothing to see, and she said, 'I can't get to you. If you can't get to me I'm lost'. Later she had that 'gloomy kitchen' dream again, but this time I came in and carried her out. I have described these phenomena in detail in *Schizoid Phenomena, Object Relations and the Self*, Parts 1 and 3 (1968). This is how the schizoid and schizophrenic has transference experiences. They communicate to us their cut-offness, and if we cannot understand that and help them, by getting slowly into touch with the lost heart of their innermost self, they are lost indeed. All that could not have been seen as far back as the beginning of this century and was not seen by either Adler or Freud, but Freud's depth psychology, in a way he hardly foresaw, going deeper than oedipal problems, has helped us most, at this vital point.

Adler's view, so far as I understand it, was that the child growing into adulthood, with a basic sense of inferiority, seeks through his 'will to power' to overcome or overcompensate for that 'inferiority' by creating a 'fictive goal of superiority', of omnipotence. As this becomes ever more unrealistic it must be shielded from the test of contact with reality. Adler (1929) wrote:

The patient makes use of the unconscious in order to be able to follow the old goal of superiority... One of his artifices is to transfer the goal into the realm of the unconscious... The frequent antithesis between the conscious and the unconscious impulses is only an antithesis of means. For the purpose of heightening the feeling of personality or the attainment of the goal of god-likeness, it is irrelevant.

In 1900-13 that was shrewd and penetrating analysis, and we should judge a man's writings always in the light of the period when they were written. But we cannot now accept that as a correct analysis of the deep unconscious. It makes it little more than one aspect of neurotic choice or stratagem; to protect godlike fantasy from the disillusioning test of contact with conscious reality, it must be made and kept unconscious. Adler's

unconscious is created by choice. He wrote:

If this 'moral' goal is hidden away in some experience or fantasy, the patient may to such an extent fall a victim to amnesia... that the fictive goal become lost to view... When the neurotic life-plan might nullify itself by coming into direct opposition with the feeling of the community, then its life-plan is formed in the unconscious... Psychotherapy can begin here by bringing into consciousness the guiding ideas of greatness, thereby rendering their influence upon active life impossible (1929, p. 230).

This is a good description of the early days of psychotherapy, when it was held that helping the patient to achieve conscious 'insight' was the curative factor. 'Insight therapy' is still a label much in use but it does not correspond to the realities of treatment. The development of 'insight' during psychotherapy is more the result than the cause of good progress; a sign that a 'growth process' is under way due to the efficacy of the therapeutic personal relationship of patient and analyst. Insight then stabilizes and helps on that process. I think that in this respect Adler stood where all the early psychotherapists stood. They put too much responsibility on the child and the patient for the existence of his weaknesses and his defences, and expected him to be able to alter himself, if he could be got to see what he was up to. Phyllis Bottome (1939) includes in her biography of Adler, as an appendix, the Memorial Address given by Dr Lydia Sicher, and she makes the Adlerian position completely clear.

Adler no longer regarded neurosis as a disease *sui generis*, but unmasked it as a social deviation, as the effect of imperfect 'cooperation' with the collective action of humanity. The neurotic is no longer to be treated as a sick person to be pitied, who by the ordinance of fate has become a victim of heredity, his environment or his instincts, but as a person who has made a mistake, who has not learned to accommodate himself to the rules of the game of life [my italics]. Perception, feeling, thinking and willing – all the bodily and mental situations of an individual – are actively directed by

himself, and are employed unintentionally and unknowingly for the purpose of safeguarding his own personal ideal, which allows him to develop an activity centred solely on himself.

Hysterical behaviour certainly can look just like that at times, if we do not recognize the terrible fears that are hidden behind the exploitative behaviour of the florid hysteric reaction. But to leave it at that superficial level of analysis does grave injustice to deeply disturbed people who are more like a person flung into the sea when he cannot swim, but only frantically clutch at anything that looks like a life-belt.

When we examine now those theoretical beginnings of psychodynamic research, we find pretty much what we would expect to find; valuable initial insights that opened up unsuspected depths. Looked at today, Adler offers a too simple theory of the self in his 'individual psychology', and Freud offered too simple a theory of 'personal relations' in his 'Oedipus complex' and 'instinct theory' but here were the two halves of the truth or the beginnings of them, the truth that a 'personal ego or self cannot be created or grow in a vacuum of personal relations, or in bad personal relations'. The unconscious is not a stratagem for hiding our neurotic choices or fictive goals; it is the accumulated experience of our entire infancy and early childhood at the hands of the all-powerful adults who formed us. We have no choice about its creation, and we can only acquire the possibility of a regrowth to normal stability and self-confidence after a bad start, if someone can give us the kind of reliable and understanding, valuing relationship that Balint called 'recognition', i.e. recognition by the therapist of the patient's actual reality as a person in his own right, in a way that slowly sinks in and sets going new growth processes leading to the rebirth of a genuine self. A human being is not born with a fully formed ego, however infantile. He is rather 'a psyche with human personal ego-potential', needing good human relations in which to grow. Professor Stoller (1968) of Los

Angeles says that the formative factor for good or ill is the 'minute by minute, hour by hour, day by day, month by month, year by year impact of the atmosphere of the parents on the child', and that is what is built-in as we grow up, as the foundation of all later adult development. Our contemporary 'object-relations theory of the personality', that a true self can only grow in the soil of personal relations with other selves, beginning with the baby and the mother, settles once for all the question of the nature of the therapeutic factor, as not a 'technique of treatment' but a 'quality of relationship'. A patient who had a psychotic mother, and began therapy as an ill man, off work and stuck in a junior position, and who has progressed steadily through a long period of therapy to the very top of his professional tree, came in recently and sat down and said straight away, 'I feel relaxed now the moment I come in and sit down. It used to be half way through sessions before I could feel like that'. His capacity to do his work in a relaxed state of mind has developed *pari passu* with his capacity to relax in sessions. There has been plenty of dream analysis, and life-story telling, and frightened and angry transferences and all that one finds in the textbooks, but all the time there has been a slow growing process of feeling more and more like a real person in relation to me. That is what we have to make possible for our patients, most of all for the deeply schizoid ones. We are in luck if we find a simple case where a symptom can be cleared up in a few weeks or months by 'insight therapy'. That can and does happen, but they are not the cases we learn most from. The deeper we go, the more severely we ourselves are tested, till finally we might say, if I may venture to elaborate the words of St Paul:

Though I speak with the tongues of men and angels, popes and cardinals, archbishops and theologians, philosophers and scientists, psychiatrists and psychotherapists, Freudians, Kleinians, Adlerians, and Jungians, and though I have the gift of prophecy (of interpretation and insight)

and understand all mysteries and all knowledge (of all the psychodynamic theories) and have not love (therapeutic love, the kind of love a genuine parent can give to a child), I am a sounding brass and tinkling cymbal.

Where real therapy is going on, we and our patients are growing together at the same time, and neither of us can be the same afterwards. What Adler called 'the power to turn a minus into a plus' is in the end the 'power to grow from being an insecure child into being an adult', and mental processes are, as he said, not causal, not driven from behind by a force, but teleological, drawn forwards to the goal of our self-fulfilment in personal relationships.

The child's ego or self can be fragmented by multiple inconsistencies in the ways adults handle him. He needs a 'whole' therapist to grow whole with. At one extreme Freud was impersonal in treatment, the interpreting 'mirror' analyst, out of sight behind a couch. At the other extreme Adler was entirely personal, even to letting patients invade his private life and follow him on holidays, not I think the best way of helping the child in the patient to grow up and go his own way. But in those early pioneering days, all methods needed to be tried; yet in the end Freud grew pessimistic about therapy and Adler did not. Not that 'personal therapy' has to go to Adler's extreme. It is true, as St John wrote, that 'perfect love casteth out fear' but therapeutic love is not subjective involvement, but objective respect for, and understanding of, the other person's reality so that he can find himself. The one absolute, fundamental need is not for 'satisfaction' or 'gratification' of instincts, but for stable psychic 'existence' itself; not a need to be sexual or aggressive or superior or to be boss, but simply to 'be', to feel so sure you are a real person that you are hardly conscious of it as you enjoy living. The ultimate fear is not of sex deprivation or persecution or inferiority, but the terrible fear of just 'not being anything', of feeling empty, a nobody, a non-person. People will do anything to

fill that gulf with compulsive repetitive thoughts or acts, anxieties, aggressions, obsessions, physical symptoms, anything, rather than be threatened by the fear of the loss of the self, of depersonalization. That is the depth to which Adler's inferiority complex and Freud's repetition compulsion pointed. Psychotherapists have no monopoly of this truth. For confirmation, may I appeal to an unexpected source. The title of a 'pop' song by Dickie Valentine is 'The Best Thing to be is a Person'.

Any discussion of psychotherapy, to be realistic, must admit that, while it can provide an answer to the individual problems of the lucky few who can get it (and however many therapists we train, their patients will still be the lucky few, especially when we remember the importance of matching patient and therapist), it cannot by itself be the answer to the massive problem of social or community mental disturbance or instabilities of personality. The work of the specialists provides the basis for the answer, but the total problem of mental disturbance is so vast as to be beyond the reach of individual therapy. Professor Sir Denis Hill has already warned us that the case load of deviant characters, drug addicts, alcoholics, sexual offenders, delinquents and so on, many of them not, properly speaking, medical cases at all, is more than the medical pro-

fession can possibly cope with, and he has called for the training of both medical and non-medical personnel in psychotherapy (1969).

But the full answer must be based on the principle that prevention is better than cure. The principles and conditions of stable, healthy personality development, as clarified by the specialists, have somehow to be brought home to teenagers, parents and teachers, and to social workers of all kinds, ministers and clergy, and even politicians and business executives. The stark truth about the causes of personality distress, and the rationalized disguises it assumes when not breaking out as illness (Freud pointed out that crime, i.e. anti-social behaviour, aggressiveness, is the other side of neurosis), and the basic necessities in the personal care of children at all age levels, beginning with mother and infant, must soak ever deeper into our culture. The process has already begun in the increasing education of all the social work professions in the principles of psychodynamics. We must give Adler his due as a pioneer of this movement, with his thirty child guidance clinics attached to schools, and lectures to teachers, and conferences with parents. The only danger here lies in its being done amateurishly. Expertly done it can nip in the bud a tremendous lot of trouble.

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The contributions of psychoanalytical theory to community mental health

BY REED BROCKBANK*

In his approach to preventive and community psychiatry, Caplan (1964) emphasizes what he refers to as the 'macroscopic' public health approach to community mental health problems. While there is little doubt that the use of the macroscopic view of the community is a necessary one and may be the one most frequently utilized in model-building for delivery of services in community mental health, it seems to this author that services and practice models must by necessity depend upon knowledge and theory gained from a *microscopic* look both at individuals as well as groups. The community mental health theory-building I will be describing will emphasize use of the 'high'-power lens of psychoanalytic investigation in order to indicate areas of knowledge on which service and practice models may be built.

It seems apparent that some activities in community mental health may require a public health or sociological approach while others will require more psychoanalytic knowledge. Since we must deal both with individuals and with social systems and groups, it would seem logical that theoretical structures for both should be present in community mental health theory.

DEFINITIONS AND SCOPE

The theory that underlies the technical practice of psychoanalysis has been called by Fenichel (1935) 'the theory of technique'. Clinically, this has to do with the theoretical reasons for a specific kind of approach to the individual patient. In this paper I will not deal with the theory of the psychoanalytic practice

model or the psychotherapeutic model. What I will present is not a *conceptual model* for the delivery of services, but rather a review of some of the theoretical underpinnings upon which service-producing models may be built.

Psychoanalytic theory, as I am using the term, refers not so much to the technique of psychoanalytic practice, but to the broad areas of knowledge of human behaviour that have evolved over the past 20 years of psychoanalytic practice and research. It is this body of observations, knowledge and theory-building that I will utilize in order to see which aspects are applicable to theory-building in community mental health.

Community mental health is defined as the generic term under which the fields of community psychiatry, community psychology, community social work, community nursing and social psychiatry all form specific disciplinary parts. In this definition, community mental health combines community and psychosocial theory as well as practice.

At present there is no unified theory underlying community mental health practice, but rather a tendency to borrow from aspects of sociology, social psychology, general psychology, learning theory, social psychiatry, public health, community organization theory, crisis theory and psychoanalytic and developmental theory. The integration of these elements and theoretical systems into a general systems theory for community mental health awaits integrators of far greater breadth of knowledge and integrative capacity than is possessed by the present writer. Therefore I will present aspects of psychoanalytic theory with which I am most familiar, and which I believe touch on or may be utilized in theory-building for community mental health. I will discuss this

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under four headings: (1) aspects of development and maturation and their phase-specific tasks and crises; (2) the dynamic, economic and adaptive points of view in conflict formation and resolution; (3) developments in ego psychology, including the concepts of ego strength and ego weakness; and (4) aspects of group psychology, including the development and maintenance of group and individual identity.

ASPECTS OF DEVELOPMENT AND MATURATION AND THEIR PHASE-SPECIFIC TASKS AND CRISES

Benedek (1952*a*) differentiates maturation from development as follows:

Maturation refers to processes of growth which occur *relatively* [my italics] independently of the environment; development refers to the interaction between maturational processes and environmental influences which lead to higher structuralization and to individual variations in the psychic apparatus.

Much has been learned about phase-specific maturation and development during the past 15 or 20 years through the usual psychoanalytic reconstructions during analysis of adults as well as children and by direct observations of infants, children, and adolescents (Spitz, 1965; Bowlby *et al.*, 1956; Offer & Sabshin, 1966). Much of this information is of crucial significance for the mental health specialist when he is working, for example, as a consultant to a nursery school or child care centre, or is contributing to a committee's deliberations for the development of remedial training for socially or intellectually disadvantaged children, or the planning of facilities for the community's handling of problems of juvenile delinquency, crime prevention, or rehabilitation of vocationally handicapped, etc. All of these and many other activities require a sophisticated understanding of child, adolescent, and adult development and their phase-specific tasks.

The minimum of those activities which are ordinarily included within the field of community mental health practice include: (1) community organization, (2) mental health

education, (3) community research and programme planning, and, (4) mental health consultation. What has come from psychoanalytic investigation is a source of considerable information to the mental health specialist in all four of these areas. Rather than attempt to describe all of the material in this very rich area of maturation and development which would fill many volumes, I will merely refer to comprehensive papers, books, and concepts which are relevant to the area of development and maturation.

Much refinement of psychoanalytic developmental theory has occurred since the early exposition of the libidinal phases of development during the first six years of life and the 'transformations of puberty' (Freud, 1905). Specialized studies of ego and superego development (Loewenstein, 1966) as well as 'the development of the sense of reality' (Ferenczi, 1913) have added much to our understanding which can be useful in community mental health and community psychiatry. The studies of Spitz (1957, 1965) are particularly important here and deserve special consideration. The development of the sense of self and the differentiating phases and the 'organizers' which Spitz outlines from three to eighteen months are of crucial significance in understanding developmental failures in the ego, which result in numerous educational defects and handicaps, neurotic and psychotic disorders of childhood and adult life, as well as behavioural problems in adolescence and a wide variety of forms of social deviance.

For example, Spitz' eight-month 'stranger anxiety' has many implications with regard to the future development of distrust, paranoia, xenophobia, and prejudice. Benedek (1952*a, b*, chs. 12, 13, 15) has written at least four significant papers on development in which she extends considerably our understanding of developmental phases in childhood, through motherhood, fatherhood, maturity and old age. The further applications by Piaget (1952) of many psychoanalytic studies to the origins of intelligence in children and to the implications for educational techniques have been

of equal significance and should form a part of community mental health theory.

Erikson (1956) has been able to integrate psychosocial developmental stages with those of psychoanalytic libido theory, which represents special importance to community psychiatry. It would seem quite out of place not to include Erikson's conceptualizations of developmental crises in any theoretical system governing the delivery of services to individuals and groups in crisis. It would be quite incomplete, for example, to study a community effort to deal with the problems of unwed mothers without giving due consideration to the adolescent identity crisis that such a mother may find herself in. The complications of being a mother without a husband with the usual family and social stigma, while still struggling with problems of an adolescent identity diffusion help make up the total picture in which the unwed mother finds herself. The same could be said of all other developmental phases that have been outlined by Erikson: for example, the relationship of the development, or lack, of basic trust in the first year of life to the future problems of xenophobia, prejudice, and even racial conflict. The above brief review represents only some of the highlights of the contributions of psychoanalytic theory to maturation and development.

THE DYNAMIC, ECONOMIC AND ADAPTIVE POINTS OF VIEW

The dynamic point of view

Prior to 1895, when Breuer & Freud (1893) published their 'Studies on Hysteria', it simply had not been possible to understand very much about the meaning of pathological behaviour or its causes except in very static, reductionistic terms, like 'neurogenic deterioration' or 'hereditary taint' or 'constitutional inferiority'. Most mental illness was regarded as organically caused by some as yet undefined hereditary or constitutional factor. Therefore Freud's notion that people could fall ill from clusters of ideas or thoughts or memories called complexes which were unconscious was a truly

revolutionary concept. It was from these early clinical studies that a conceptual model of the structure of the human mind was built which was later seen to be in a constant state of dynamic equilibrium.

The word 'dynamic' is a term borrowed from physics which relates to forces acting in opposition to each other. These forces are seen in biological, psychological and social terms. On the biological side are the instincts, which are the motor which drives the total system of the organism and around which other dynamic forces operate. It is because of the influence of these forces that conflict within the organism as well as between the organism and its social environment develops.

Because culturally determined values and habits exist both inside the individual (i.e. superego and ego ideal) as well as outside, these values constitute demands which necessitate constant testing, altering and modifying of both the internal conditions as well as the external ones. Multiplying this complexity is the fact that whatever developmental and maturational achievements are made are constantly being challenged by frustration and at times failures so that an intermittent regressive return to an earlier developmental phase of success or failure is a *necessity and a requirement* that the external environment and culture must allow for and at times even encourage if mental illness is to be prevented and equilibrium to be maintained and mental health encouraged. The Shriners' Annual Convention and the regressive behaviour allowed on this yearly 'breaking-loose' is a case in point.

It must by now be obvious to the mental health professional that an understanding of the functions of the ego, both autonomous and defensive, is a necessary part of recognizing when and in what ways conflict is being dealt with. The existence of and necessity to take into account these defences and these dynamic forces, particularly those which are unconscious, both in individual and in group life, require that the mental health professional operate beyond the level of the common-sense assumptions of the average well-informed

layman. For example, it is one thing for a layman or an indigenous non-professional to be involved as a leader of encounter groups, T-groups, or Synanon, etc., which may add to or disrupt the mental equilibrium of certain people in the community. It is quite another for the mental health professional to be able to evaluate carefully the impact of such developments, attempt to understand what is going on so that he can have certain criteria for determining what is helpful to the mental health of the community and what may be detrimental.

The economic point of view

The notion that the psychic system functions as a result of something called psychic energy and that there must be sufficient energy invested and deployed or utilized or kept in a reservoir for surplus and reserve and that this must be replenished, and how these things are accomplished is a complex subject in itself. Suffice it to say that sufficient rest, hygienic measures, work, diversion, recreation, etc., are a necessary part of this process. Care, attention, love, and even social and financial security, play their role in the maintenance of this energy system. Protection from excessive worry, fear, shame, doubt, guilt and adequate external controls to bolster internal controls, etc., all act as economic energy-saving or replacement. Without these the likelihood of greater and larger numbers of schizophrenic breakdowns and other forms of maladaptation are likely to occur. This aspect has been well described as the 'social breakdown syndrome' by Gruenberg (1967). Also, social acceptance of any management of adequate outlets for sublimation and discharge, which at times may even include some aspects of prejudice, are all part of the preservation of mental health. We must be constantly thoughtful about how long excessive tension can be tolerated in a given psychic system before the drain on energy resources will deplete the reservoir; or, where there is an oversupply or flooding of one part of the system, producing megalomania, or of the body ego, producing hysteria or hypo-

chondriasis. When these pathological developments occur in individuals or in groups, then the community mental health specialists need to be aware of how one might eliminate the excessive energy cathexis in one area or another, or how to increase the reservoir of energy when it becomes overly depleted.

The adaptive point of view

The adaptive point of view immediately brings up the most crucial aspect of psychoanalytic theory for community mental health. Crisis theory and much of sociological and anthropological theory interdigitate here with psychoanalytic concepts of the process of adaptation. Adaptation, or 'fitting together' as Hartmann (1939) refers to it, is a highly complex process involving all three components of the human psyche and is not merely a function of the ego. It involves particularly the integrative and synthetic functions of the ego and the relationship of the id and the superego to these ego activities. These internal arrangements and alternations we refer to as *autoplastic adaptations*.

In addition, the concept, of course, includes all of those intrapsychic activities as they relate either directly or indirectly to that large 'outer-foreign country' which psychoanalysts refer to as 'external reality'. The capacity to alter and change one's external environment we call *alloplastic adaptation*.

The historical background for the adaptive point of view in psychoanalysis was the concept of the constancy principle. Fechner first postulated that the organism seeks pleasure and attempts to avoid pain while thus maintaining itself without too much excitation in a steady state. Thus a mechanism for the maintenance of a dynamic equilibrium is present in all organisms, including man. Every stimulus, both within the organism and external to it, threatens this equilibrium and disrupts it to some degree. Also, each change in the internal, intrapsychic equilibrium will reflect itself in a change in the equilibrium between the individual and his environment and vice versa.

In this regard it must be kept in mind that there are both *progressive* and *regressive* adaptations and either of these may be pathological or normal. Pathological adaptations have been called *maladaptations*, whereas normal adaptations have been referred to as *well adaptations*. For example, a pathological regressive adaptation may be seen in the response of a schizophrenic patient to stress by retreat to a catatonic cocoon-like position from which he is safe from threatening and debilitating stimuli from within or from without. Whereas a normal regressive adaptation can be seen in creative acts, or in humour, or in play and games. Many forms of recreation which are institutionalized represent regressive adaptations which serve the ego and often preserve mental health. Progressive adaptations, on the other hand, are those which occur in the direction of development; for example, toilet training, weaning, etc.

It is essential that community mental health personnel recognize and help to institutionalize social outlets and child-rearing practices which will allow for and encourage both progressive and regressive forms of adaptation.

One other conceptualization needs to be mentioned here and that is the concept of coping and the distinctions that are to be made between coping mechanisms and ego defences. By coping mechanisms, I refer to the learned behaviour of the organism to take necessary rational action which is goal-directed and which is vital to the prevention or resolution of a crisis state. We must consider here *capacity for coping* as well as the learning processes which lead to the development of adequate coping mechanisms; just as we refer to *capacity* of the ego to offer sufficient ego defences for its own preservation. If a child grows up in poverty, without adequate stimuli and sufficient support and care, as well as trust and hope, it is quite likely that the capacity of his ego to develop coping mechanisms may be quite limited so that later in life one crisis follows upon another simply because there are so few mechanisms for preventing or heading off a threatening crisis situation. In other

words, his alloplastic adaptive ability may be seriously defective. Whether or not this can be compensated for by educational efforts or other preventive efforts is one of the challenges in primary prevention that faces the community mental health movement. The distinction between so-called coping mechanisms and ego defences is that coping refers more to the adaptive capacity of the ego to take appropriate rational action. In the past psychoanalysis has paid only scant attention to this aspect of ego functioning. It is likely that psychoanalysts in the future will give increasing attention to this aspect of ego psychology and adaptation.

THE CONTRIBUTIONS OF EGO PSYCHOLOGY, INCLUDING THE CONCEPTS OF EGO WEAKNESS AND EGO STRENGTH

When psychoanalysts speak of ego psychology, they by no means have any intention of ignoring the other components of the mind which help so much to determine what the ego is and what it is not. One of the misconceptions that has already arisen is the assumption that ego psychology deals only with conscious motivation and behaviour. This, of course, is far from the case since much of the ego's activity is unconscious in the descriptive sense and is preconscious in the structural sense. The ego organizes and controls motility and perception, but much of, or perhaps most of, this control function is carried on outside of conscious awareness. Perceptions of self and external worlds are most frequently laid down in memory traces which are outside of one's conscious thinking. The ego's 'sense of reality' (Weiss, 1960) as well as its reality-testing activities are for the most part automatic and outside of conscious awareness. Action, motor discharge, and thinking are all under the control of the preconscious ego. Another very important activity of the ego is known as the function of delay. In this we perceive in ourselves and others the ability to tolerate frustration. Careful evaluation of all of these activities in individuals and groups in

crisis and in populations at risk is essential to the community mental health enterprise.

The last significant function I will refer to, and one of the most important of all for mental health, is two separate functions called *integration* and *synthesis*. We are fully aware that disparate and often conflicting wishes, needs, demands and expectations confront the ego at every turn of the individual's life. The ability to integrate these various conflicting needs, so that the individual can live in some degree of freedom from conflict and thus preserve energy for rational and creative action, is indeed one of the largest tasks of the ego. The ability, on the other hand, to synthesize and to bind together certain elements to make new combinations and sublimations is where the creative and productive aspects of the ego comes into operation. It is not surprising that our understanding of creative action has received an added impetus as a result of further understanding of the ego functions of intergration and synthesis. It is in these two activities of the ego that creative potential and 'positive mental health' in the Jahoda (1958) sense becomes possible.

These and many other ego activities are buttressed by what might be called *reserve forces* or *ego defences*. When we speak of ego strength and ego weakness, therefore, we may be referring to any one or several of these ego functions or defences, and we must keep in mind that we are thinking of it in a dynamic sense rather than a static one. By this I mean that the ego is strong or weak depending not only on the adequacy of its developmental and maturational and genetic aspects, but also upon the strength of the other forces with which it must contend in the superego, the id, or in the multiple vicissitudes of the external environment. This being the case, we can speak only of the relative strength of certain ego functions depending upon what particular pressures they are under at the particular time we are making our observations. This conceptualization makes it possible, therefore, to consider that if certain community mental health activities can relieve some excessive

environmental stresses or excessive excitation, then the individual egos of large numbers of people may be strengthened. The same could be said of the effect on superego strength or id strength, and the subsequent influence that this has on the strength of the ego. For example, how much influence, either negative or positive, do certain religious concepts and practices have on the strength and power of the superego in its struggle with the ego, or how much do, say, dress design or social attitudes toward sexual expression influence the relative strength of the ego with regard to its struggle with libidinal drives?

ASPECTS OF PSYCHOANALYTIC GROUP PSYCHOLOGY, INCLUDING THE DEVELOPMENT AND MAINTENANCE OF GROUP AND INDIVIDUAL IDENTITY

This last area of psychoanalytic interest is one which I regard as very closely allied to many of the interests of community mental health. As far back as 1920, Freud stated:

In the individual's mental life, someone else is invariably involved, as a model, as an object, as a helper, or as an opponent, and so from the very first individual psychology is at the same time social psychology as well. . . (Freud, 1921).

Freud was not content to look only at the one-to-one aspects of human behaviour. He was fully aware that group psychology played a significant role in every person-to-person relationship. There has been an awareness both before and after Freud's painstaking and in-depth studies of human life from the normal phenomena of dreams, jokes, mourning and parapraxes, to the psychopathological studies of hysteria, neurasthenia anxiety states, obsessive neurosis, paranoia and melancholia, as well as the paraphrenias that there is the significant factor of group psychology which influences both normal and pathological psychodynamics. Yet, since Freud's 1921 book, group psychology has been given only scant attention by psychoanalysts.

Freud was very much aware of the importance of group psychology and this awareness had considerable influence on his development

of the *structural theory* (Freud, 1923). Just prior to Freud's development of his structural concepts of id, ego and superego, he had been greatly influenced by a book written by the French social psychologist, Gustav LeBon (1920). LeBon's work on *La Psychologie des Foules*, written in 1895, had a catalytic influence on Freud's interest in the effect of group psychology on the ego and particularly on the development of the ego ideal. The study of the importance of significant figures in dyadic relationships, i.e. mothers and sons, mothers and daughters, fathers and daughters, and fathers and sons, has been extended to considerable depth in psychoanalysis, as we know, because of their consistent reproduction in hypnotic as well as psychoanalytic transference situations. It is seldom, however, that we fully recognize that these relationships represent *groups* of two and in fantasy at least several more persons are involved. In fact, the dyadic relationship was regarded by Freud as a group of two and he was convinced that group psychology played a significant role even in small groups of two people.

In speaking of the two-person hypnotic relationship he wrote as follows:

We may also say that the hypnotic relation is (if expression is permitted) a group formation with two members. Hypnosis is not a good object for comparison with group formation because it is truer to say that it is identical with it (Freud, 1921). Freud meant by this that precisely the same psychodynamics were responsible for the phenomenon of hypnosis and group formation; both situations involve the projection of ego ideal (superego) on to an object, i.e. hypnotist or group leader. He was also aware that in group formations of larger than two members, significant identifications occur between the members because of the sharing of common sentiments and affects towards the leader which explains much of the cohesive qualities of larger groups. The cohesiveness of dyadic groups was explained on the basis of aggressive and libidinal attractions in the form of transference.

Freud had accepted LeBon's (1920) and

McDougall's (1920) ideas that human psychopathology and psychodynamics are altered and significantly influenced by group formation. Freud was aware that human behaviour is simply not the same in isolation as it is in the presence of one or more other persons, particularly when this results in the formation of a *psychological group*. LeBon had demonstrated that once the relationship between two or more people developed certain libidinally binding ties, a 'psychological group' is formed and this formation influences the behaviour of the individual in that group in significant ways.

A group will be defined in our discussion not by its size, but by the psychological characteristics that obtain when any number of people come together with a common aim or purpose and as a result of this gathering develop certain libidinal ties to each other and to the leader, or a principle (in the absence of a leader) which unites them into what may be called a *psychological group*. Therefore the influence of group psychology will be seen to operate in groups of two as well as groups of 20, 50 or 100, etc. The fact that LeBon's studies of 'des foules' was translated into the word 'crowd' does not justify an arbitrary separation between the psychology of a smaller group and larger crowd. LeBon himself made it clear that the characteristics he was referring to could be seen in small or in larger groups, depending upon the feature that the sentiments expressed by the crowd do not conform to those of the individuals who make it up, but to what he called a 'collective mind' with clearly defined characteristics. He states:

At certain moments half a dozen men might contribute to a psychological crowd which might not happen in the case of hundreds of men gathered together by accident. On the other hand, the entire nation, though there may be no visible agglomeration, may become a crowd under the action of certain influences (LeBon, 1920).

One may speak of the characteristics of different sizes of groups, from the dyad to the triad or to a larger group, of the characteristics of the family group, a cast, a profession, a social class, a nation, or a race, but we will

confine ourselves to those psychological characteristics of the coming together of people, large or small. In all of these instances our frame of reference will be the psychodynamics and psychopathology of the individual as he is influenced by the group.

It should be mentioned here that groups have been classified, primarily by sociologists and social psychologists, in a variety of ways from *primary* and *secondary* groups (Cooley), *communities* and *societies* (Tonnies), *statistical* groups (Mannheim), or *psychological* groups (LeBon and Freud). Using other criteria groups have been classified into *organized* and *unorganized*, *artificial* and *spontaneous*, to include all kinds of groups, such as the church, society, the crowd, the mass, the public, the state, or the nation. However, as indicated, we are less concerned with sociological classifications and typology than we are with the psychological processes that can be found in common among the various types of groupings.

The behaviour of the individual in a dyad and in a larger group alters from that in isolation in significant ways. In general, one may describe these differences in behaviour under two headings: First, behaviour that is characteristic in groups and can be attributed to quantitative differences in certain psychic phenomena that occur in the individual when he is in a group situation; and second, behaviour that represents psychodynamic reactions (defences) to the above phenomena. The psychic phenomena producing the first kind of behaviour include: (1) a lessened sense of individuality, (2) a diminished sense of individual responsibility, (3) increased contagion and suggestibility (with increased belief in the magic power of words and the demand for illusions), (4) lowered critical discriminative intellectual function (increased credulity), (5) increase in impulsivity, affectivity, changeability, irritability, excitability, and action, (6) creation of transference readiness and intensification or transference potential. The above phenomena are countered by behaviour arising from psychodynamic reaction formations to the above, including: (1) exaggerated

efforts at reality testing (consensual validation), (2) attempts to re-establish and solidify the threatened sense of identity and individuality, (3) excessive superego demands on the group and increased superego strivings, (4) increased defences against transference and regression, i.e. attempts to focus exclusively on the interpersonal as a defence against the intrapsychic, intellectualization, avoidance, distancing and flight.

LeBon and McDougall emphasized the diminishing of certain critical intellectual functions of the individual egos that occurs regularly in group formation. It is this author's opinion that this phenomenon is a result of two dynamic processes: (1) externalization of the ego functions of evaluation and discrimination on to the group or on to the group leader, and (2) ego fusion with other members of the group. It is postulated that anonymity, so characteristic of groups, occurs as a result of this ego fusion. A closely related phenomenon is a lessening of the sense of individual responsibility that would logically follow from the superego externalization.

The feeling of anonymity enables the person in a group to do and say what he might not do or say in other circumstances. In therapeutic groups, for example, patients are stimulated to 'blurt out' things that they would be more restrained about in a dyadic situation, or at least they would be more inclined to use certain isolating techniques if they were not in a group. Thus the lessening of critical and intellectual functions with group formation leaves the person more vulnerable to the claims of his instinctual drives. He often has the experience of saying in a group things that he did not realize he felt and that he was not aware of before speaking. Freud (1921) believed that many of the phenomena of group psychology could be explained as a result of a diminution of the intensity of the counter-cathetic, repressive barrier of the ego, and at the same time an increased need for satisfaction of the demands of the libido and, as we would add, of the demands of the aggressive instincts.

Freud pointed out that human beings tend

to cure themselves and they utilize various techniques for this purpose. In an autoplasic way, this attempt at self cure takes place by the formation of symptoms or character traits. Every human being tries to cure himself by love; either loving or being loved. A closely allied psychodynamic equivalent aspect of this is the joining of a group: thus the present clamour to all kinds of encounters – Synanon, Esalen and T-groups.

The source of the drive to group formation was believed by Trotter to be instinctually determined and he labelled it the 'herd instinct'. Freud, however, saw in it the operation of the libidinal instinct (i.e. the drive to love or be loved). Thus people form groups for the same reason that they seek cure by psychoanalysis and the binding force that holds a group together is the same force that keeps the patient in the psychoanalytic situation, namely the transference. The essence of transference is the projection of superego introjects, and since this kind of projection on to the group or on to the group leader is characteristic of group behaviour, group formation strongly encourages transference formation.

Basic to the group instinctual drive is the need to 'belong', which can be best looked upon as a need for a regressive return to the primary symbiotic unity with the mother. As Balint (1959) pointed out, this regressive pull and the ego's defences against it form the essence of the to and fro struggle of the patient in the psychoanalytic situation. It is my contention that this same dynamic exists in the formation of groups. The need to belong is the need to belong to the mother, to be part of her, to be one and the same. The fear that many incipient or chronic schizophrenics have of groups arises from their intense fear of a loss of their already weakened sense of identity and of ego boundaries that might result from such a regression. Their defences against this regressive trend often keep them from group formations; the intense anxiety and panic that is aroused by the group must be defended against by distancing and isolation. The schizophrenic gives evidence that what is projected on to the

group is not only his superego, but also certain aspects of his ego, and this is much more threatening. This identity diffusion is in contrast to that of the adolescent who actively seeks group formation in an effort to establish a solid sense of his own identity.

It would follow from the above that the contagion and imitation of emotion so characteristic of group members are manifestations of this regressive return to symbiotic unity with the mother where the sharing of emotion and contagion are such paramount features. A readily observable feature of group formation in adolescence is a marked amount of contagion and imitation of emotion. Again, unlike the schizophrenic, the adolescent seeks out and is less threatened by this regressive experience. McDougall (1920) wrote of the positive and creative effect of this imitation as follows:

Imitation is the great agency through which the child is led on from the life of mere animal impulse to the life of self-control, deliberation, and true volition. And it has played a similar part in the development of the human race and of human society. Imitation is the prime condition of all collective mental life.

Briffault (1927) outlined biological evidence of a positive correlation between the development of human intelligence and freedom from the instinctual rigidity found in lower animals. He postulated that this relative freedom from restraint arises from the prolonged mother-child unity. He was aware also that the critical feature of the experience with the mother for maturation and development is the phenomenon of imitation.

To summarize the effects on the individual of his dependent, symbiotic attachment to the group: First, he gives up a certain modicum of his individuality in order to adjust himself to the mores and values of the group. Secondly, it is characteristic of group as well as mass psychology that the individual members tend to utilize less individual reality testing and to rely instead on generalizations by the group and on their stereotypes in place of more careful discriminative judgement. Thirdly, the individual with a threatened sense of self-

identity may attempt to bolster his lagging self-identity by group membership and may join others with the same difficulty and the result is a regression of ego controls and a loosening of previously self-contained impulses, especially hostility, with a consequent increase in prejudice, bigotry, discriminative acts, or even violence. Contagion and the imitation of emotion, which are the characteristic features of groups, add impetus to these impulses. Fourthly, the results of the above feelings and behaviour may cause the individual to lose even more his already shaky self-esteem, and his self-identity suffers another blow, with a consequent increase in fear, panic and disequilibrium.

Finally, it is understood that identity crises are an unavoidable part of ego development, and as such play a catalytic role in maturation. These crises can contribute either to mental health or to mental illness, depending upon the nature and effect of the traumatic events experienced by the individual during his lifetime, and depending also upon the degree of success achieved in handling each crisis as it arises. The implications for prevention and for possible therapeutic intervention are clear, but we must be alert to both the negative as well as the positive and creative effects of group formation and group action, and how group psychology may influence the finalization of behaviour.

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Bereavement in a Samoan community

BY JOAN ABLON*

Clinicians and behavioural scientists have noted that persons in crisis and post-crisis periods are a high-risk population for temporary, although frequently disabling, emotional problems. A large body of literature focusing on bereavement has described symptomatology of grief and has suggested possible programmes for the alleviation of some of the common problems shared by survivors.

This paper describes the supports built into the social structure of the Samoan community of an American West Coast metropolitan area that contribute to the alleviation of emotional distress characteristically associated with bereavement. The social, religious, and financial security available for Samoans at such times offers a striking contrast to that available for most segments of the larger American society. The Samoan family and community have prescribed expectations and actions for caregiving services in times of acute crisis, and these services are evidenced some ten or more times a year when the death of a Samoan occurs in this community.

The data presented here result from (1) interviewing and observation of death and crisis situations over a two-year period in a Samoan population of 5000 persons, and (2) interviews taken during a follow-up study conducted five years after a catastrophic fire that occurred in this Samoan community in 1964. The data concerning crisis situations emerged from a larger study conducted by the author, a social anthropologist working out of a university-based community mental health training programme. The central purpose of the

study was to identify, describe and analyse indigenous cultural patterns retained by Samoan immigrants which contribute to or hinder urban adaptation. The extraordinary support provided by the traditional affective ties of family and community in times of crisis offer one striking example of cultural patterns contributing to urban survival.

The Samoan Islands constitute one of the Polynesian group in the South Pacific Ocean. The language, cultural patterns and physical type of the islanders are related generically to those of Hawaii, Tonga, Tahiti and other islands that are classified as 'Polynesian'. The population described in this paper have migrated from American Samoa, a United States territory currently administered by the Department of the Interior. The remaining Samoan islands compose Western Samoa, formerly a mandate of New Zealand, but now an independent parliamentary state.

Sizable immigration from American Samoa to Honolulu and the American mainland cities began after 1951 when the Department of the Navy, which had administered the islands since 1900, closed the naval base at Pago Pago on the major island of Tutuila, and the administration of the territory was transferred to the Department of the Interior. Many naval personnel and their dependants were moved to Honolulu and from there to the West Coast cities in the late 1950s. A good number of these naval personnel have since retired and settled in California. Many other persons have emigrated to seek wage labour which will enable them to buy material possessions that they could not afford in Samoa, even though their actual living standard was comfortable. Many come to seek a mainland education for themselves or their children. Some come simply to investigate the larger

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world. An estimated 15,000 to 20,000 Samoans now reside in California – chiefly in San Diego, Oceanside, the greater Los Angeles area and the San Francisco Bay area. These persons have adapted with relative ease to an environment that could hardly be more different from that of their native islands. Characteristically, both men and women are fully employed in a variety of occupations. They lead full and active lives centred on their families, churches and jobs.

BEREAVEMENT: SOCIAL NEEDS

Silverman (1967) chronicled the periods of stress experienced by widows following the death of their spouses. She detailed the particular needs of the widow at these times and the kinds of family and community services that typically or ideally function to meet these needs. She suggested the 'initial impact' phase may last from one month up to six months or more. The second 'recoil' phase is not always clearly differentiated from the impact phase and can cover a period of time extending from one month to one year or longer. During this period the widow experiences her loss most acutely, as her numbness lifts and the ability to feel returns. The final 'recovery' period occurs any time within two months to two years after the death. The tasks of this phase deal with letting go of the past and building a new life. Silverman noted that mental health professionals know least about this period. There commonly is a dearth of community resources to help the bereaved. Traditional agencies and even such caregivers as the clergy may not be effective. Silverman (1969, p. 334) stated: 'Widows I have talked with felt that neither friends, family, physicians, nor clergymen, for that matter, were very helpful.' These persons tried to push them too quickly through the grief work that Lindemann (1944) and others have suggested is necessary for a healthy recovery. Silverman proposed that widows who have recovered from their own mourning may be the most effective caregivers for the bereaved,

even though they are strangers. Moreover, some of the most helpful contacts may be in the form of long telephone conversations rather than face-to-face interaction.

Maddison & Walker (1967) and Maddison (1968) discussed some of the complex social factors that are involved in 'satisfactory' or 'unsatisfactory' outcomes of bereavement. They found that a high frequency of social interactions perceived as unhelpful by the widow during the three months following the husband's death appears to be an indicator of unhealthy recovery or 'unfavourable outcome'. A reading of the bereavement studies suggests that social support which is quantitatively and qualitatively adequate in all phases of the bereavement crisis is necessary to achieve a satisfactory emotional adjustment.

Lindemann (1944) defined what he called a 'remarkably uniform' grief syndrome, the chief features of which are somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, loss of patterns of conduct, and sometimes adoption by the bereaved of elements of behaviour of the deceased. The duration of the grief reaction depends on how successfully 'grief work' is accomplished, that is, the speed and manner with which the bereaved emancipates himself from his bonds to the deceased and readjusts to his new social reality. Although Lindemann labelled the grief syndrome as pathognomic, this phenomenon may well be culturally linked to members of our own society with whom Lindemann worked. Interviews with Samoans suggest that the syndrome does not occur in this form among bereaved Samoans. Likewise, grief work appears to be rapidly and less painfully accomplished by Samoans because of ritualized family and community support, and cultural attitudes relating to death.

SAMOANS' REACTION TO DEATH

The West Coast Samoan population described here has retained and integrated many traditional features of Samoan custom into a new urban life style (Ablon, 1971 a). The key

social unit is the extended family, composed of a wide variety of persons related by blood, marriage, and adoption. The extended family household often consists of six to ten persons. Household composition is fluid, and various relatives come and go, the duration of their stays being dependent on their reasons for being in the household and in the area.

There are at present 13 Samoan church groups in the area, representing a variety of Protestant, Mormon, and Catholic groups. Following the advent of the first Christian missionaries to Samoa in 1830 the Christian religion was effectively integrated with the traditional Samoan social structure. The churches today remain the centres of social as well as religious life in Samoa and the mainland cities. Samoan churches developed with the mushrooming of Samoan settlement in the mainland cities in the late 1950s and early 1960s to meet the needs of the immigrants for religion and fellowship of other Samoans. The churches cooperate with family units in carrying on a modified-traditional pattern of funeral observances.

The occasion of the death of a Samoan invokes great activity involving not only relatives, friends, and churchmates of the deceased, but also at least some members of most of the Samoan churches of the area. The church attended by the deceased hosts a number of formal Christian ceremonies prior to interment. This series of services held at the time of death emphasizes relations between churches and families. In addition, traditional ritual exchanges of goods and donations of money activate and place in high relief the network of relationships between family members and members of the Samoan community at large, all of whom may donate money to the immediate family of the deceased. The money that is collected, from \$3,000 to \$10,000, is used to pay for funeral and burial expenses and for food necessary for the related intricate social events. Money that is left over after all expenses are paid for is distributed among the immediate family and the bilateral kin. I have described elsewhere the complexities

and cultural richness of Samoan funeral rites (Ablon, 1970).

The immediate rallying of kin and friends around the household of the deceased is both spontaneous and expected. The gathering of the closest bilateral kin who reside in the area and the arrival of relatives from Samoa, Hawaii and mainland cities contribute with studied efficiency to take the burden of decision- and arrangement-making off the shoulders of spouse, parents, or children. There are many minds and hands to help with the numerous practical matters that must be arranged, to console the grieving, and to take care of children who may be left without a parent.

Samoan identity establishes imperatives of responsibility to one's fellows. Death clearly evokes support not only of relatives, but of other Samoans who may have been friends of the deceased, who migrated from the same village, or who had only a bare acquaintance with him. If a relative cannot attend the services, he will at the least stop by the house of the deceased to make his presentation and offer consolation. The key Samoan value of reciprocity is evidenced strongly in funeral behaviour. If a person does not meet the needs of others, they may not meet his in similar circumstances.

THE FIRE

The fire of 1964 provided an opportunity to examine the role of social and cultural patterns as they affect individuals, families, and community in a period of acute stress. The fire occurred at a Samoan dance held in a Catholic church social hall. It resulted in 17 deaths and 70 moderate to severe burn injuries. Almost all of the dead and injured were Samoans. Interviews were held with 18 families that the fire touched by death or injury, Red Cross disaster officials, physicians, nurses, attorneys, and other Samoan families who were involved with fire victims over the following days and years. The 18 families constituted just less than one-third of the units included in the Red Cross files making up the

master list of those affected by the fire, and about three-fourths of the families who remained in the area at the time of the research. Because the follow-up study was carried out five years after the fire, the materials chosen for examination were limited to those that realistically could be elicited in significant detail and with some degree of accuracy. Although Samoans rarely talk about the fire spontaneously, their memories of it and of subsequent events are quite keen and detailed. Medical personnel were eager to talk about their experiences and also retained clear memories of the event.

By all accounts, Samoans as individuals and as family groups appeared to have absorbed the disaster amazingly well. Samoans speak of themselves as being strong and knowing that one has to take hardships without complaint. They exhibit a great tolerance for pain, death, and calamities, regarding these as aspects of life that one must bear, sanctioned by a Christianity that dictates an acceptance of God's will as non-reversible fate. Many informants offhandedly stated that despite painful events of whatever magnitude, the mechanics of life must, after all, go on.

Medical personnel repeatedly remarked on the 'stoical' manner in which patients and their families withstood injury and death the night of the fire and during the period following. The consoling force of religious fatalism in the acceptance of death and tragedy was frequently mentioned. Patients were described as being stalwart and uncomplaining, no matter how serious their burns were. Those medical personnel who had to inform relatives of the death of their loved ones were struck by the outwardly unemotional acceptance of this reality (Ablon, 1971 b).

Of the 18 families contacted, four contained women widowed by the fire. Three of the widows were in their early 20s at the time of the fire; one was a newly-wed of one week, and two were far along in their first and second pregnancies, respectively. These three remarried within the next 14 months. The fourth widow, a woman in her 40s with six

children, has not remarried. She has applied her considerable astuteness and energy to building up one of the few Samoan-owned business enterprises on the mainland.

These widows all reported acute initial shock and distress when confronted by the death of their husbands. Their brief discussions of such distress, however, quickly turned to the amount of assistance they were given by relatives even before the death and extending into the months and years that followed. They immediately were surrounded by their own or their spouses' relatives who took over responsibility for funeral arrangements and household management. In the case of the three younger women this family assistance obviously served to ameliorate their initial emotional distress. The fourth emphatically stated that 'nothing' could help to relieve her grief.

Questions concerning the specific elements of the grief syndrome as described by Lindemann elicited little response, as might be expected some five years after the event. However, some listened with wonder to the description of such symptoms, repeatedly stating that Samoans 'do not have such things'. Some positive responses were forthcoming concerning continuing fears and dreams. One of the three widows who experienced the fire stated that she has continued to have dreams of the fire. Three of the widows reported fears when attending public gatherings, and say that they tend to keep their families near the door in such a situation. One reported that at a recent event when a fire dance was performed she went outside to her car and waited out the performance there. (By my own observation that evening, several other families who had been in the fire also left at the beginning of the dance and returned immediately afterwards.) Two of the widows stated that they are particularly sensitive to the possibility of household accidents.

At the time of the interviews all of these women were, like most Samoan women, extremely busy mothers and homemakers as well as being fully employed outside of their homes. All are living in new homes purchased

through settlements resulting from a common lawsuit following the fire.

Maddison's study (1968) suggested that young widows and those left with dependent children are the widow population at highest risk for emotional problems. Yet Samoan women in these categories appear to make relatively rapid and satisfactory adjustments. The many functions performed for them by their extended families serve to alleviate some of the complicating problems. Silverman (1969) stated that widows contacted through her project worried about loneliness, financial problems, and raising children alone. The widow 'talks about the emptiness of the house, the fact that there is no one to take care of, and no one with whom she can share her evenings and weekends' (p. 335). The nature of the Samoan extended family household precludes many of these specific anxieties. This busy household more than likely existed before the husband's death and normally may be projected into the future, although individual persons may change. In this household there are always many people about, there are one's own or others' children to take care of, and help is forthcoming from other adults and older children.

Immediate funeral expenses are met by the funds collected following the death. Long-term financial support is assured either by family assistance, by the woman's own potential for working as is the Samoan pattern, or, as a last resort, by a return to Samoa and the ever-available family resources there.

Marris's thoughtful treatment (1958) of the considerations and problems of remarriage as expressed by the London widows he interviewed points up both the emotional and social needs created by the death of spouses and the variety of handicaps the widows perceived in the process of a successful remarriage to meet these needs. Samoan widows appear to experience few of these handicaps.

For Samoans the extended family structure with its adhering patterns of behaviour and responsibility provides the stabilizing force of personal and social life. The ideal and actual

life pattern for the Samoan woman is mother, homemaker, and, for most, the vocational role of practical nurse or nurse's aide. The typical life style is what might be termed by non-Samoans as unusually gregarious and even frenetic in its social orientation. There are very few single Samoan women. Remarriage, then, is the desire, expectation, and reality for these women. One who was badly scarred from her burns made one of the few statements that suggested anxiety about scarification. She stated that she feared she was scarred so badly that no man would want her. Although she was the last of the three to remarry, she did so only 14 months after her husband's death, when the child with whom she had been pregnant at the time of the fire was ten months old.

The most extreme grief responses came from two of the three women who lost children in the fire. One of the two was a woman in her mid-50s who lost a 27-year-old adopted son. Her only other child was an adult woman who had her own family of six children and lived across the country. This woman reported to me that the death of her son had made her 'crazy'. Eighteen months following the fire she was hospitalized for a six-week period with a condition characterized in hospital records as a 'psychotic depressive reaction'. Her family described her behaviour before hospitalization as bizarre and paranoid.

The second bereaved mother was a woman in her late 40s who lost an adopted child, one of two adopted daughters, and the one whom she regarded as her favourite, who 'did everything' for her. This woman related a number of dramatic details surrounding the fire and its aftermath, which, when compared with official records, appeared to be more fantasy than fact. She reported a highly dramatic rescue from the burned building many hours after, in fact, the last victims had been removed. She also reported a much longer stay in the hospital than was the case and told of the delivery of her third child there some two months after the fire. Records revealed that this child was the offspring of her surviving

unmarried 16-year-old daughter. She dressed this male grandchild whom she had reported to be her own son in girls' clothing until he began school. When a doctor in the local public health centre attempted to discuss with her the dangers for the child of her continuing to do this, she replied that she was trying to make him take the place of the beloved daughter whom she had lost in the fire. When I interviewed her, the child was almost six years old and was then dressed in male attire.

At the time of the interviews both of these women continued to visit the graves of their children weekly to bring food and gifts and to speak with the dead. The first had resumed work a few days following the death of her son and has continued to work regularly to the present, with the exception of her period of hospitalization. The second was so badly burned that she has not been able to work since her recovery.

The third woman was the 38-year-old mother of seven children at the time of the fire. She lost her second youngest son, a boy of seven, and she, her husband, and her eldest daughter were all severely burned. When she and her husband were asked about the symptoms of bereavement reported by Lindemann (1944) they responded by laughing. He said:

Samoans don't do that. People don't worry or grieve. Look at Mrs X. She had just gotten married and a few months later married another man. All of the women who lost husbands married fast.

His wife defended this by commenting that the women were young and should be married. However, both agreed that there was no widespread depression.

Americans are crazy. They get so worried. In the paper or on television they get so upset about some little thing that would be nothing for us. We take such things for granted.

When told there was one woman who had gone to the cemetery every week for years to visit her son's grave, they reacted with disbelief. They said in some cases this might take place for a year, in keeping with the

traditional mourning period for Samoan families, although this period of mourning is rarely followed today in either Samoa or the mainland cities. Such behaviour as described would be in the extreme for contemporary mourning custom and its continuation for five years would be highly unusual.

Questions about fears and dreams elicited substantial responses from these three women. The first, who was hospitalized, responded that she thinks about her loss all the time, although not about the fire. She was the only one of the three who was not present at the fire.

The second, whose injuries have left her a partial invalid, stated that she continues to think about the fire during the day when she is by herself waiting for her children (her daughter and grandchild) to return from school. She also thinks about it at night when she goes to sleep, although she has had few dreams about it. She does not like to go to dances or gatherings, perhaps more significant in her case because of a past career as an entertainer in large group situations. The third woman, who could perhaps be considered here as the 'favourable outcome' mother, stated that she often is afraid to go to dances or gatherings, fearing that there might be a fire. Her husband quickly retorted he does not have this fear. Observation at Samoan events, however, has revealed that this couple do attend many gatherings. They left such a gathering in 1969, when a fire dance was announced, returning shortly after its completion. She remarked that sometimes when she goes to see their doctor they talk about the fire and she gets a 'little upset, but when I leave I forget all about it'.

The historical and personal materials available on this small number of parents who lost children suggest a few tentative, but common, threads. The two women who acted out their losses so dramatically exhibited behaviour considered deviant by other Samoans who suffered similar losses. These women had rather atypical past histories for Samoan women of their ages. One had been in this country for many years, travelling widely as an enter-

tainer. Both had been divorced and were in their second marriages. Divorce is not common among Samoans of their age. Each had only one other child, and the child who died in both cases was adopted. Large families are desired and expected by Samoans, and families of one or two children are unusual. Adoption is common, particularly in cases where a couple beget few or no children. Two of these women were in their menopausal years. They did not have large extended family households to occupy their attention and to aid in restabilizing their home lives. The third woman returned immediately to her busy round of household management with four remaining children in the home as well as to her work as a nurse's aide. Again, the extended family household appears to have been a significant restabilizing force for emotional rehabilitation.

Volkart & Michael (1957) pointed out some of the difficulties of attempting cross-cultural studies of subjective grief reaction, in contrast to focusing on bereavement behaviour, the acting out of personally or culturally prescribed ritual that is more easily observed and described. The reference quoted above to the quick remarriage of one widow suggests that grief reactions may not have been accurately assessed by other Samoans at the time of the disaster, let alone by a non-Samoan investigator five years after the critical event. The widow referred to above had, indeed, stated some of her distress to me in simple but moving terms:

I didn't feel like working. I didn't feel like doing anything. I just stayed at home for months and months. I just couldn't work. I didn't wish to think of anything.

One informant who was severely burned and had been widowed shortly before the fire made the following statement in answer to my questions about the grief responses of several relatives who suffered losses in their families:

People held up pretty well. Maybe for a month or so they wanted to stay to themselves and think a

lot about it, but after that, they just had to move on and they didn't let it preoccupy them. Samoan people have problems but they just don't complain and run to a doctor about every little thing like Americans do. They are used to putting up with more.

CULTURAL PATTERNS MITIGATING GRIEF

Some of the cultural factors that serve to mitigate acute emotional distress of the bereaved Samoan are: (1) the ritualized, multifaceted support of family and community as described above; (2) the consoling force of the Christian belief system; and (3) Samoan attitudes towards death and the loss of a family member.

Social supports

Samoans take for granted the assumption of caregiving responsibilities by and for their relatives in a crisis. Non-Samoan informants, frequently medical or agency personnel, stated that the helping activities of Samoan families are unique in their experience with response to crisis and death. A funeral director commented that he feels a chief reason Samoans manage their grief so well is that they have 'extraordinary financial and moral backing'. He pointed out that many of his clients have only one other person to rely on for practical matters and comfort, while Samoans have a whole 'colony'.

Informants categorically stated that no matter how infrequently they see any relative they would feel responsible for helping him with money or services at times of crisis or need. Obviously, personal attitudes towards individual relatives, as well as the condition of the household finances at the time one is asked to give, would enter into the carrying into action of this idealized statement. Observations and interviews concerning behaviour at the time of specific crisis situations that arose during the course of this research suggest that most relatives do indeed respond spontaneously with such aid when the need arises.

Religious beliefs

At the time of death, religion often appears to be the chief consolation for the survivors. While Christian ritual elaborately dispatches the dead, the ministrations of the church through ritual behaviour and the Christian belief system offer effective balm and consolation for the mourners. In the very act of withstanding the sacrifice of their loved one they are able to show their dedication to God and Jesus. This continual reaffirmation of their faith allows some survivors to speak of the time of death as their happiest hour, of sacrifice accompanied by understanding and blessing. One prominent Samoan minister who counselled with many of the bereaved following the fire emphasized this theme. 'They had to forget. I would talk to them and then they would even forget that they had a family member who died. Or after a while they would thank God that this had happened to them.' A surgeon who treated many burn patients felt that the typical response to death and to pain and severe scarification was often 'whatever God wills'. He gave the example of informing a husband of the death of his wife. The man in turn passed on the news to a group of relatives waiting outside. They immediately fell to their knees in prayer, and then left without demonstrating what the surgeon would regard as any observable signs of grief.

The importance of religious beliefs in mitigating grief for the Samoan might be contrasted with the findings of Maddison & Walker (1967, p. 1063). They found it difficult to determine whether exhortations by others to the widow that 'she would see her husband again during some future existence', or 'that it must have been God's will that her husband should die', contributed to favourable or unfavourable outcome widows.

It was, however, observed that such discussions were only occasionally perceived as helpful, subjects who had beliefs of this type tending to regard such interventions as gratuitous and unnecessary, while other subjects without any profound religious conviction found such attempts at comfort

meaningless and often extremely irritating. A strong impression is gained that the height of the bereavement crisis is an exceedingly poor time at which to introduce religion in any evangelical fashion.

Attitudes towards death

Samoan attitudes towards death and the acceptability of replacement of individuals in family roles serve to preclude the acute trauma of bereavement experienced by many Americans. Samoans view death as one of the natural events in the experience of the living. In contrast, death in the United States, in general, is a subject that is hidden away, or at least ignored as much as possible. There is little ritual at the time of death, and most persons attend only the funerals of those with whom they have had close interaction. For Samoans, death has little of this mystique.

Mead (1961) discussed the way in which birth and death were presented matter-of-factly to the Samoan child of 1925. She vividly described the mode of primitive autopsy at the grave to determine the cause of death, and the postmortem Caesarean operation customary for women who died in pregnancy. Children routinely viewed these events. Mead stated that these 'horrible, but perfectly natural, non-unique occurrences' were presented as a legitimate part of the Samoan child's experiences. In contrast, the American child, whose circle of intimates is much smaller, may only experience the death of one close relative in his years of growing up. All of the negative affect surrounding one highly charged emotional experience may be carried over to other deaths that he encounters in his later life.

Volkart & Michael (1957) pointed out that there is a cultural bias in projecting the acute grief reaction that may be expected for bereaved Americans on to other groups with culturally different family systems. Differing family systems can enhance or reduce the initial vulnerability of persons in bereavement by the emotional weight invested in non-replaceable role situations. Thus the typical American small nuclear family tends to channel frequency and intimacy of contact among the same few

persons, breeding overidentification and overdependence on the persons occupying a relatively few highly charged social roles. Emotional attachments are fostered to particular persons with unique personalities in addition to the roles they fill. In contrast, in an extended family system many social roles might be filled by a number of persons.

The fact that the social role of the bereaved person in our culture may not easily cope with the problem of replacement is, therefore, a local one. It is bound up in our system of interpersonal relations, the kind of selves we tend to develop, and is exaggerated by our cultural emphasis on loss. In this way the bereaved person has no automatic cultural solution to the problem of replacement. . . . To the extent that social and cultural conditions encourage interpersonal relationships in which overidentification, overdependence, sense of loss, hostility, guilt, and ambivalence are bred in profusion, and to the extent that the social role of the bereaved person does not take account of these feelings and the needs they inspire – to that extent bereaved persons may often be unintended victims of their socio-cultural system (Volkart & Michael, 1957, pp. 300, 301).

CONCLUSION

This account of Samoan family and community behaviour at times of death describes

a social system with a remarkable programme of immediate services for acute crisis periods. Culturally determined attitudes towards death and misfortune serve to mitigate the severe grief reaction that we in America consider to be 'normal'. This view of the dynamics of one indigenous system of caregiving activities and associated cultural values presents a cross-cultural perspective on effective and available support in a family-orientated and community-orientated society, in contrast to the larger American society in which many persons must rely on impersonal community aid. A closer scrutiny of other cultural and social systems that function effectively to alleviate distress at the time of death may increase our understanding and definition of caregiving alternatives for the bereaved in our own society.

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Psychological disorder and training for pastoral care

BY DOUGLAS HOOPER,* JOHN ROBERTS* AND
ELIZABETH McMEEKAN†

No literate reader needs to be told that the clergy have had an age-long concern for psychologically disturbed people. This has varied a great deal throughout the centuries as McNeill (1951) testifies, and initially the reform movement of the late 18th century (Zilboorg & Henry, 1941) was pioneered in England by the clergyless religious group The Society of Friends. It is difficult to find evidence of the Church's activity in the reform movement and the majority of writers when reviewing this activity even ignore the most important Quaker initiative (McNeill, 1951; Weatherhead, 1951). Yet despite this, clergy and their flocks have visited the old 'asylums' as well as the new 'hospitals' to bring both the religious observances and charity of many kinds. In more recent times the position of the clergymen within the hospital has become a dilemma, so that some offer only the performance of formal religious ritual and visitation whilst others have striven for a more therapeutic role. Outside in the community the clergyman's training has never really fitted him to lend his pastoral aid to a significant proportion of his community, and his relationship with helping agencies has often been equivocal (British Council of Churches, 1969).

Various changes in society have led to the demand by ordinands and trained clergy for increased training in this area of human ills as they have become aware of the conflicts of present function. In the U.S.A. this need has been matched by the growth of various training schemes almost to the point of creating psychiatric specialists amongst the

clergy. In part, this is in response to a clear need in the U.S. community as was established by Gurin *et al.* (1960), who found that more people would go initially to a clergyman if they were upset and disturbed than would go to any other agent in the community. No such evidence is available in Great Britain and it is in any case doubtful whether the clergy would be used in quite the same way. Yet with at least 15 per cent of the community having a significant degree of psychiatric disorder, and a severely stretched community mental health organization, the clergy as a group have obviously both the tradition and the situation within the community to do a great deal of valuable work from the mental health point of view.

To meet the need for training in this country, a number of training schemes have been developed, including the 'school' of clinical theology directed by Lake (1966). The present paper describes the Bristol training scheme, which is not especially novel but is really primarily concerned to evaluate the effect of such training upon the students – which very clearly *is* novel. Almost no attempts have been made to evaluate these training schemes. Lake & Harman (1968) carried out a simple post-training self-assessment scheme which showed that participants were satisfied with their training, but this can hardly be called adequate evaluation.

THE TRAINING SCHEME

The scheme under evaluation was one designed for ordinands in the Bristol area together with a few young parish clergy. There were 24 Anglican students, 19 Free Church students, and four working clergy. The training extended over two years and started with two

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initial lectures giving a general framework for understanding psychiatric disorder. The authors believe that the provision of psychiatric jargon and some quasi-medical understanding are not especially helpful to clergy in the community since their relationship is *pastoral* and not medical. The lectures were therefore not descriptions of psychiatric diagnosis and treatment. Following the lectures, the students were split into groups to visit local psychiatric units every two weeks. There they were allotted one or two patients and their task was to talk with the patient with a view to getting a first-hand experience of a disordered person as well as developing interviewing skill. At the end of the interviews they returned to the University to discuss the hospital experience with tutors who were members of either the Department of Mental Health or the Department of Theology. Every student had one group tutorial with every staff tutor in rotation so that this teaching experience was roughly equated, although, of course, tutors and students were together at different times during the total course. At the end of the second term all the participant tutors and students assembled for a last lecture/discussion.

THE STUDY

Training schemes like the one described here are not simply designed to give students a new experience, but also attempt to bring about more lasting changes in the attitude of those who participate, so that from then on they will respond differently to people with psychological difficulties. There are three possible ways of evaluating any such change: one is to observe at first-hand the behaviour of those who have been trained; the second is to ask others to judge this by relating their experience of the student; and the last is to check the view of the students by testing their orientation towards the psychologically disturbed.

Ideally, evaluation should use all three methods. In this instance this was not appropriate since most of the students had had no

personal field of professional endeavour like a parish or hospital. The most appropriate technique fell under the third heading and this was used by us both before and after training.

The method we adopted was to administer to the students the Opinions about Mental Illness (OMI) Questionnaire developed for rather similar purposes by Cohen & Struening (1962). This questionnaire has been designed to measure five discrete aspects of orientation towards mental illness. Each student filled out the questionnaire immediately before the first lecture and was asked to select his own control by asking a fellow-student at the same college to complete it. This was repeated at the end of the course, with the untrained students also repeating the exercise. Obviously these were 'control' students in a very narrow sense since they were particularly selected by their colleagues. This had interesting results which we shall refer to later.

RESULTS

The OMI questionnaire allows us to specify the areas in which change occurs rather than simply relying on an overall blanket measure, and we shall therefore discuss the scores in this way in detail taking each factor separately. The five factors which can be derived from the questionnaire (and which are said by the inventors to have negligible intercorrelations) are:

A. *Authoritarianism*. The extent of authoritarian submission and also identity of the mentally ill as inferior and needing coercion. (24 items.)

B. *Benevolence*. The acceptance of a kindly paternalistic view towards psychiatric patients. Essentially humanistic rather than scientific/professional. (9 items.)

C. *Mental hygiene ideology*. Degree of acceptance of a 'health' orientation to psychiatric disorder. Consort with psychiatric professional attitudes. (10 items.)

D. *Restrictiveness*. Perception of the mentally ill as socially threatening or non-

Table 1. *Items and score ranges on OMI questionnaire*

Factor ...	A	B	C	D	E
No. of items	24	9	10	11	7
Score range	24-120	9-45	10-50	11-55	7-35

Table 2. *Median and range of scores on OMI questionnaire*

(*n* = 37 experimental; 20 control.)

	Factor A	Factor B	Factor C	Factor D	Factor E
Pre-experience					
Median	94	25	25	43	20.5
Range	76-112	19-32	19-33	34-52	13-28
Pre-control					
Median	89.5	25	23.5	43	22
Range	77-110	21-30	15-29	36-50	17-28
Post-experience					
Median	99	26	24	45	20
Range	79-113	18-33	16-32	31-54	15-32
Post-control					
Median	90	26	24.5	43.5	22
Range	77-115	22-33	16-34	35-48	14-33
Theoretical median	72.5	30.5	30.5	33.5	21.5

threatening and the consequent attitude to constraint. (11 items.)

E. *Interpersonal aetiology*. Acceptance of psychosocial factors as leading to disorder. (7 items.)

Of the original 62 items, one relating to abolition of the death penalty was dropped as inappropriate. The remaining 61 were rated on a five-point scale from 'strongly disagree' to 'strongly agree'. The factors are composed of varying numbers of items which are listed after the description of the factors given above.

Scoring is inversely related to all factors so that the greater the score, the less the agreement with the stated attitude. The pre- and post-experience median scores for both groups of students, together with the observed range and theoretical median, are all given in Table 2.

First we will examine the students themselves, and then make comparisons with their untrained colleagues. It is important to note that our interest is in the relative change scores

and not in the absolute scores obtained on any factor. There are no norms which we could appropriately use and so we are making no assumptions about the strength of each factor prior to training. Our prediction was that all scores would move in the direction of greater tolerance for, and understanding of, the person with psychological disorder. Our training was also set up to bring this about and we are therefore entitled to evaluate our results by means of one-tailed levels of significance.

The degree of significance and the direction of the change in questionnaire scores are shown in Table 3, change being marked as positive if it is the direction hypothesized. The results are based on the 37 students (out of 47) for whom we had completed questionnaires on both occasions. This is obviously a selected subsample but remains valid within itself. Table 4 shows the same data for the non-participant students, of whom there were 20 available for comparison on both occasions. There were no significant differences between

the participant and non-participant students either before or after the training period.

These tables demonstrate that the changes occurring amongst the participant students were not matched by equal change amongst

Table 3. *Changes in attitude amongst the participant students*

Factor	Significance*	Direction of change
A	$P = 0.0001$	+
B	n.s.	?
C	n.s.	+
D	$P = 0.004$	+
E	$P = 0.07$	+

* Wilcoxon matched pairs signed ranks test.

Table 4. *Changes in attitude amongst the non-participant students*

Factor	Significance*	Direction of change
A	n.s.	+
B	n.s.	?
C	n.s.	-
D	n.s.	+
E	n.s.	+

* Wilcoxon matched pairs signed ranks test.

their non-participant fellows. Yet shifts in general attitude did occur amongst the latter group even though the change did not reach significant levels. We need, therefore, to look at the scores of the two groups on each separate occasion. When these were examined by the median test, they revealed that there were no significant differences between the participant and non-participant students prior to training. But what about the same comparison following the training period? When these were examined in a similar way, they showed (surprisingly) that again there were no significant differences between the two groups following the training. This means that the scores of non-participants also moved in the same *direction* as their fellow students, but obviously not to the same *extent*.

Examination of the general attitude levels by comparison with theoretical median scores shows that as a group the theological students were non-authoritarian, paternalistic, and non-restrictive, as well as accepting a 'mental health' ideology, but equivocal in aetiological views. Of these attitudinal factors, the ones which were significantly affected by training were authoritarianism, restrictiveness, and their aetiological view, with the tendency for students to become even more liberal. Thus the course seems to have particularly affected personal attitudes towards psychiatric disorder, and to have had little effect on their general orientation to patients. In view of their liberal cast of mind, any marked alteration would have been surprising. The aetiological factor (E) is obviously slightly different from the others, and perhaps the shift here is as a direct result of the teaching in psychopathology, and certainly conforms to the view of several of the tutors.

DISCUSSION

These results are somewhat intriguing. They certainly demonstrate the importance of evaluation in training schemes like this one, since the aims of any such project need careful evaluation against the actual effects rather than those which may be fondly imagined by the organizers. We need, first, to refer back to the original scheme which we have described above. The project was conceived in three parts. At the beginning and end the teaching experience was shared by all the participants, but for the period in between there was significantly less sharing. The students from the five colleges visited five different psychiatric centres, three of which were psychiatric hospitals whilst the fourth and fifth were psychiatric units in a general teaching hospital group. When they came after these visits for seminars, they were combined into groups which, whilst themselves identical right through, nevertheless were made up of students visiting different psychiatric units. In addition, a student visited only one of the units for the whole training period, but was exposed

to eight tutors throughout the period. Perhaps, therefore, the most potent force for change was the small tutorial group which would enable any one student to check out his experience against his fellows.

It could be that the most significant part of the training was the personal experience of the student rather than the more formal learning. This would certainly accord with the initial aim which was not to create pseudo-psychiatrists but to make students examine their original ideas against a background of novel experience. This might account for the most striking change, which was in the general area of authoritarianism rather than in specific attitudinal components.

Of the other components, the most puzzling result is the significant change of factor E, but only a slight and non-significant change of factor C.

In the original study, Cohen & Struening (1962) describe factor C as being summarized in the statement 'Mental illness is an illness like any other', while factor E emphasized the interpersonal aetiology of psychiatric disorder. It became clear to us during the tutorials that the majority of the students were concerned with two main themes, namely whether mental illness was an 'illness' in the sense that something is organically wrong with the patient's central nervous system; and also the degree to which it is possible to distinguish between the effects of sin and the effects of illness on psychiatric disorder. Throughout the course the interpersonal factors were emphasized much more than the intrapsychic or biochemical aspects of disorder. It can be argued that this emphasis was successful to the extent that there were changes in the desired direction as the results show for factor E, but that on the whole the students did not shift their position on their general categorization of mental illness. In remaining in this position they were, in fact, being more logical than we expected,

as to have shifted very far on factor C would have been paradoxical in the light of their movement on factor E.

Finally, there is apparent lack of effect in comparison with control students. This is much easier to understand. We were able to collect two completed questionnaires from only 20 students. It is reasonably probable that these were either interested students or were the friends of particularly involved participant students. Although we lack the firm evidence required (partly because the results were computed after the student group had graduated), it seems reasonable to suppose that we are not dealing with a general attitudinal drift, but rather with a secondary education of the control students through their peers.

In general, we were obviously dealing with a highly selected group of students. Their general attitudes towards mental illness were already very liberal and unauthoritarian and where change has occurred it is in the direction of intensifying these views. Fortunately this is consonant with the aim of the training programme, which was to emphasize many aspects of psychiatric care with which the students were already in sympathy.

SUMMARY

Forty-seven ordinands and young clergy were given some experience and training in dealing with psychiatric disorder. Training included lectures, practical experience and a number of seminars. Before and after training, students completed the Opinions about Mental Illness questionnaire, which was also completed in the same way by 20 non-participant theology students. The five-factor questionnaire revealed that all students were fairly liberal in their psychiatric views, and the training seemed to intensify these views in several of the attitudinal factors. Non-participant students also showed some changes although not to a significant degree. It is argued that this was a secondary educational effect resulting from the selection procedure.

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National and international studies in mental retardation*

By JACK TIZARD†

I first met Ronald Hargreaves in January 1954. I had been invited, at rather short notice, to act as a consultant in mental health to the World Health Organization Joint Expert Committee on the Mentally Handicapped Child, and it was made clear to me that the World Health Organization expected me to be in Geneva before the end of 1953 – for budget reasons as I later discovered rather than because they urgently needed my presence there.

Dr Hargreaves was at that time Chief of the Mental Health Section of the World Health Organization, doing what was perhaps the most influential and effective work of his career. I was immediately impressed by him, and also somewhat intimidated. He seemed to know everybody and to have read everything. He spoke comical fluent French in the morning in the office, and English only after lunch. He smoked one of those new-fangled pipes with a metal stem, the like of which I had not seen before, though they were in fact English. He still had a military cut about him, and drew extensively and appositely upon British army practice to illustrate the strengths and weaknesses, the possibilities and the limitations, of a general staff, an intelligence unit, a complex organization and the planning of a campaign in mental health. He told very funny stories and mixed easily, though he was, I felt, an immensely reserved man and I never got to know him well as a person, though I did in fact see quite a lot of him as a temporary colleague in Geneva on more than one occasion.

Those six weeks or so that I spent in the

* The 6th Hargreaves Memorial lecture given to the Leeds Psychiatric Association on 23 October 1970.

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Mental Health Unit in 1954 set me thinking about a range of problems I had not previously thought through: and from that time to the present my own thinking and research has been rather different from what I imagine it would have been had I not met Hargreaves and listened to him.

I saw rather little of Professor Hargreaves after his return to England. On several occasions he invited me to come to Leeds and I intended to, though for one reason or another I kept putting it off. Then I heard – at a meeting of the Research Committee of the Mental Health Research Fund of which Hargreaves was an active and effective member – that he had died a few days before. It seemed hardly possible.

I thought I could best honour Ronald Hargreaves' memory by considering the problems which first brought me to his notice, namely the possibilities open to us today to do what has come to be called transcultural research in mental retardation. By this I mean research which is carried out in more than one country, and which is designed to answer a specific question or questions using comparable methods.

About the desirability of carrying out studies in more than one *centre* there can be no doubt whatsoever. For at least 150 years, in the physical and biological sciences, replication of scientific research by scientists working in other laboratories has been standard practice. In medicine also replication is the rule – and with every therapeutic advance or purported advance there are scores of clinicians in every country who are anxious to test its efficacy. After all the patient who does not get well lives on in the mind of his doctor long after he is dead; and therapeutic failure is as much an affront to the physician as

educational failure is to the teacher. This is why, incidentally, the criticism which is sometimes made that the medical profession is intensely conservative therapeutically is so mistaken, and why the man who has a secret remedy, or whose therapeutic notions are not taken up by his colleagues, is almost always a quack. For the most serious mistakes in medicine – and indeed in education – are more likely to spring from the credulity of practitioners who seek new treatments, rather than from the scepticism of those who refuse to admit that anything new can be good. Hence the whole paraphernalia of modern scientific medicine, with its insistence on therapeutic trials, on double-blind procedures, on adequate diagnosis and rigorous specification of treatment conditions, on evaluation of results using objective and reliable criteria – all this designed to protect patients against the too enthusiastic adoption by physicians of new treatments, and to protect physicians from being guided simply by clinical intuition or what the drug firms tell them.

How far is it possible to emulate these excellent practices which have developed in general medicine over a long period of time, in various fields of mental retardation? What opportunities are there in the social and behavioural sciences for work of a comparable nature, and how can we utilize them?

INTERNATIONAL STUDIES OF RARE DISEASES

The most straightforward examples of international research in mental subnormality have arisen following the discovery of a rare and specific disease. When Fölling in Norway first demonstrated in a specific form of mental retardation the presence of an abnormal metabolite (phenylpuruvic acid) in the urine, his work was quickly replicated in other countries. Penrose soon discovered similar cases, and established the main fact about the genetical transmission of the abnormality which he renamed phenylketonuria. Shortly afterwards Jervis in the United States dis-

covered that the primary site of the lesion lay in a defective liver function, rather than a defective brain, thereby demonstrating, as Haldane put it, a relation between mind and matter as surprising as transubstantiation, and a good deal better established. So the stage was set for all the subsequent work on this condition: work to establish the frequency of heterozygosity in the general population; tests to detect 'carriers' of the recessive gene, which, in the homozygous condition resulted in mental defect; studies to analyse the variance in raised phenylalanine levels in blood or urine; work to produce an effective treatment and to evaluate it.

Research on all of these problems is proceeding in many countries. What is more, the model of the disease of phenylketonuria is a general one: at least 60 other inborn errors of metabolism have been discovered which result in recessive, genetically determined diseases, diagnosable biochemically, and in some cases treatable by special diet or other means.

International research in this field, as for example in the field of cytogenetics, has for the most part proceeded apace in medical centres in widely separated parts of the world because of the rapid diffusion of knowledge published in scientific journals. All one needs for such research to go on is, it seems, free publication and its international dissemination.

There are, however, two possibilities for deliberate extension of this standard scientific practice which are peculiarly applicable to rare diseases. One is epidemiological and genetic, the other therapeutic. Problems of phenylketonuria can be used to illustrate both types of research. Clinical and genetical studies of phenylketonuria and of other biochemical abnormalities are currently being undertaken in more than one country by Robert Guthrie, originator of the Guthrie test for PKU, and Arthur Veale, Professor of Genetics in the University of Otago, New Zealand. They are working together to determine the incidence and genetics of various inborn errors of metabolism using the total population of newborns in New Zealand and

in the Islands of the South West Pacific which have links with New Zealand.

The necessary conditions for this venture were provided by a technological advance and by the existence of adequate maternal and child health services covering a population of about three million people in New Zealand, and other south-west Pacific islands which have contact with New Zealand. The technological breakthrough was Guthrie's, who has discovered a way of automating his biochemical assays so that a single drop of blood, taken from a neonate and placed on a filter paper, can be posted to a centre where its chemical properties can be analysed in such a way as to detect biochemical abnormalities. By placing a tiny piece of the bloodstained filter paper in agar solutions containing the appropriate chemicals, cultures from as many as 100 babies at a time can be developed at a single go. The samples are placed in rows, like cup cakes in a baking tray, each child's specimen being allocated to a specific row and column of the tray. After an appropriate period of time an abnormal growth in any particular spot in the tray can be seen at once by visual inspection. Then it is a simple matter to consult the key to the layout, and to identify the child whose specimen has not behaved normally. Because the whole procedure has been largely mechanized it has become possible to screen hundreds of bloods a day, and because the technique is so efficient only minute quantities of blood are required for each of the mass screenings of the different biochemical constituents.

However, in addition to sophisticated biochemistry and ingenious gadgetry, the existence of this programme also demands an adequate public health and clinical obstetric and paediatric service. Practically all doctors and all maternity units in New Zealand and the Islands have been brought in, so that they routinely send blood samples of all newborns to Professor Veale.

In order that this should happen the first condition, clearly, is that doctors and maternal child health services should actually exist, and that these should be sufficient to take care of

the needs of the total population in the areas they serve. Furthermore, the people running these services must be convinced, and the general public likewise, of the value of the routine screening they are called upon to partake in. The bargain which Professor Veale has made with them is that he gives them immediate feedback about any abnormalities he discovers, and in return they take the necessary clinical steps to deal with these and in doing so provide Veale with further information about families.

A second type of research on specific diseases which probably *requires* international collaboration also arises out of the fact that the dysfunctions I have been speaking of are extremely rare in nature. Moreover, the manifestation of the abnormality – of phenylalanine metabolism, for example – is not uniform, and response to treatment is variable. Thus there is still controversy about the circumstances in which dietary treatment of phenylketonuria is beneficial, and there remain many puzzling problems about the incidence of the condition, about what actually happens to children who are not treated, whose treatment starts at different ages, is more or less controlled, and lasts for differing periods of life. In these circumstances it may be desirable or even necessary, to conduct research in more than one country, if only because of the shortage of cases.

In principle it would be easy to carry out longitudinal studies of untreated cases of PKU almost anywhere in India, Africa or Latin America, given that screening was easy and treatment exceedingly difficult and expensive. But there is no denying that to propose clinical trials in undeveloped countries which could not be undertaken ethically in one's own does raise serious ethical issues. However, as Fox has shown in regard to TB in India, and Waterlow & Dean in regard to infant malnutrition in the West Indies and East Africa, these ethical difficulties can be solved in a manner which not only brings good to the patients and to the countries concerned, but also advances scientific knowledge. Inter-

national agencies could play a bigger role than they have done in sponsoring such research.

Unfortunately only a tiny proportion of mental retardation can be directly attributed to diseases which are at present diagnosable in a strict sense. In most cases the cause is unknown, or the handicap appears to be overdetermined – a resultant of many factors. What scope is there for international collaboration here?

INTERNATIONAL DIAGNOSTIC EXERCISES

The first requirement for any clinical research is agreement about diagnosis. If clinicians unwittingly classify the same condition differently, or use the same term to describe quite different clinical conditions, effective communication is impossible. Before we can begin to engage in collaborative study we must establish reproducible criteria of diagnosis.

The World Health Organization has since its inception sought to improve communication among research workers and governments by publishing, at ten year intervals, an International Classification of Diseases, Injuries and Causes of Death. The first editions of the International Classification of Diseases were indeed published before WHO came into being, but it is only since 1965 that actual research on this problem has been undertaken internationally – under the auspices of WHO.

The problems of defining diseases, particularly those which manifest themselves as behavioural abnormalities, are formidable. In part they arise from the fact that what passes for abnormality in one setting may not be abnormal in another. Penrose, for example, analysing the rapid rise in the prevalence of mild retardation during the years of compulsory schooling made the following point about it:

To illustrate how closely the diagnosis of mental defect is related to failure at school, I quote from the Wood Report. The incidence of ascertained cases of mental defect, in the population at all ages, was given as 8.6 per thousand, but when the age

groups are taken into account, a most peculiar phenomenon appears (Penrose, 1949). The notified cases of this supposed disease of mental deficiency are lowest between 0 and 4 years, highest in the quinquennium 10 to 14 years and lower again in the subsequent age groups. Viewed by an epidemiologist, who did not know anything about the pathology of the condition notified, the distribution would give the strong impression of a disease with onset usually after the age of 5 years and with greatest risk in the 10 to 14 year range, adults being again less susceptible. It would also seem to be a chronic disease and one which probably carried a mortality rate higher than that of the general population. What happens in this period from 5 to 15 years, which is so dangerous in this respect? The answer, of course, is that the children are exposed to the practice of education. It would not be unreasonable to assert that the educational system was a cause, perhaps the chief cause, of mental deficiency. It would be hard to find a clearer demonstration of the arbitrary nature of the current definitions of mental defect and the obviousness of social environment as a factor in determining incidence.

It has been urged as an argument for pessimism that the Royal Commission of 1904 only found half as many defectives in the population as did the Wood Committee 25 years later. In view of the different methods of ascertainment and definition in the two surveys and the lack of attention paid to age grouping in the first survey, the comparison is, I believe, valueless for scientific purposes. To infer that the basic abilities in England and Wales had decreased during the intervening 25 years, from these sets of figures, would be as absurd as to suppose that the Danes, who have nearly six times as many certified defectives per thousand population as the French, are, on that account, inferior in basic intellectual level (Penrose, 1950, p. 129).

Another problem arises from the likelihood that the same kinds of disordered mental processes may show themselves in different forms. It is an old mental hospital joke that whereas in the United States paranoid schizophrenics rush up to strangers and button-hole them in order to involve them in their delusional systems, in this country similar patients sit morosely in a corner of the ward muttering to themselves; and it is said that in parts of South Africa only violence, often culminating

in murder or serious suicidal attempts, is sufficiently dramatic to bring a black man to the attention of the medical authorities (if he is lucky). Be that as it may, we know from experience in Britain that the manifestations of mental disorder change over time, so that interpretations of apparent changes in prevalence present difficulties. We also know that different diseases or injuries may give rise to the same behavioural outcome – any serious injury to the brain for example is likely to lead to mental handicap.

A third problem which leads to diagnostic confusion concerns the names which are given to similar types of mental dysfunction. In the United States, for example, psychiatrists have tended to diagnose schizophrenia more frequently than they do in Britain. In consequence it is impossible to say whether the frequency of schizophrenia as diagnosed in this country is greater or less than it would be found to be in the United States if the same criteria were used. In mental deficiency practice almost all our diagnostic labels are confusing, being used in different senses by different writers.

During the last five years the World Health Organization has begun to tackle these diagnostic problems. A series of meetings has been held in different parts of the world which has had as its objective the study of diagnostic variation between psychiatrists using standard clinical material. Two kinds of diagnostic exercises have been carried out: one based on written case histories, the second on video-tape interviews of psychiatric patients. Seminars have been conducted on schizophrenia, on child psychiatry and in mental retardation in which these techniques have been employed to highlight disagreements about diagnosis, with a view to standardizing assessment procedures. There is no doubt that in this they have been conspicuously successful. If, as is planned, psychiatrists in different countries follow up these seminars with subsequent work which builds upon what has been done, and if they are able to pool their results in international meetings there will be a substantial reduction in the noise/signal ratio in this particular kind

of international communication. For it should be noted that where, as is the case with *severe* mental defect, there is reasonable agreement about criteria, comparable prevalence rates have been established in many developed countries in Europe, North America and the British Commonwealth. Where, however, criteria are not well established, as is the case with so-called mild mental retardation (IQ greater than 50), prevalence rates differ widely from one country to another and from one survey to another within a particular country. And where living conditions are radically different from those which obtain in industrialized countries, prevalence rates even for *severe* mental subnormality are correspondingly difficult to assess and to compare.

COMPARATIVE EPIDEMIOLOGICAL STUDIES

If diagnostic criteria can be agreed upon, the way is open for comparative studies of the incidence and prevalence of mental handicap that will lead to the elucidation of those problems of aetiology, prevention, treatment and management which form the basic stuff of social medicine.

There are none the less strategic problems which arise in the execution of such studies, if they are carried out from more than one centre. How far is it possible, for example, to use entirely standardized procedures, and to ensure that these are applied in a uniform way by all of those involved in the exercise? Is it possible to develop a methodology for social medicine and for social science which is fully applicable to *different* cultural settings? Is the increase in information which is gained from wide-ranging studies, over several countries, offset by the difficulties which are inherent in carrying such studies through? Are they indeed feasible in practice?

The conditions which apply to the successful undertaking of prevalence studies of specific diseases apply with equal force to investigations in which diagnosis is based on behavioural rather than biochemical criteria. To undertake any successful epidemiological study we must

have criteria of diagnosis which are of known reliability and validity, and we must have adequate case finding procedures. Gross abnormalities are easier to study than mild ones, so-called qualitative deviations from the average or norm are often easier to assess than quantitative ones. Population surveys are easiest to organize at the time of birth, or during the years of compulsory schooling. In general, epidemiological studies are immeasurably more difficult where there are no services – which provide both a rationale for the inquiries and incidental information about how best to go about them.

For the epidemiologist interested in mental handicap, some but not all of the conditions that facilitate epidemiological inquiry can be satisfied. Data obtainable at birth are relatively useless for prognostic purposes except in the case of rare, genetically determined disorders which result in almost all cases in severe mental handicap. (Non-specific indicators such as AGPAR scores, or low birth weight, or short gestational age, or duration of labour, though of some prognostic significance are not themselves reliable indices of later mental functioning.) Studies of adults (except perhaps at the time of call-up in those countries which have conscription) are in practice ruled out for any but the most handicapped. We are left with children of school age, and IQ data as criteria.

Though compulsory schooling makes population based inquiries of children relatively straightforward to plan, cross-cultural comparisons of mental retardation which are based on IQ data are subject to many qualifications. I think, like Vernon, that the comparison of the IQs of children who live in very different social circumstances is a futile, as well as a politically mischievous activity; and I would regard the attempt to carry out truly international surveys of mental retardation, at a single point in time, and using a standardized method of procedure, as mistaken. They would impose intolerable constraints upon the research teams and would probably give rise to a series of inadequately controlled studies in which gains

apparently obtained through standardization were lost in the carrying out of the field work. Much better a series of independent studies, undertaken at appropriate times by persons who though aware of what their predecessors in other countries or at other times have done, reserve the right to depart from their procedures if it seems in the interest of their own inquiry. The real value of comparative studies is likely to come from the replication of, or the failure to replicate, functional associations within populations, rather than from differences in reported prevalence rates in different populations. In this respect alone there may be a difference between comparative studies of specific diseases such as mongolism or PKU and surveys of assessable but not medically diagnosable conditions such as mental handicap.

The possibilities opened up by such research can be well illustrated by the study, recently completed by a team from the Albert Einstein School of Medicine, New York, and the Medical Research Council's Obstetric Medicine Research Unit in Aberdeen, of the epidemiology of mental subnormality in Aberdeen. Dr Herbert Birch and Sir Dugald Baird and their colleagues who were responsible for this investigation conclude their report on it by commenting that the absence of fully comparable studies in other communities makes it impossible for them to determine the degree to which one may generalize from their findings. The examination of similarities and differences among communities provides, they say, the only sound basis for deciding which findings are general and which are particular to given settings. They themselves raise some important questions for others to follow up. For example, low birth weight appears to have adverse consequences for intellectual growth when post-natal environment is sub-standard, but no apparent negative consequences when the environment is favourable. Thus a black child of low birth weight in an urban ghetto may be more likely to develop into a mentally subnormal child than would a white child of the same birth weight living in a high income

family. Mild mental subnormality without demonstrable central nervous system damage may exist only in the lower social classes and not in the children of families in the upper social classes – another finding that suggests that minor levels of damage, when combined with unfavourable post-natal developmental circumstances, result in mental subnormality, whereas comparable damage is insufficient to produce mental subnormality when the post-natal environment is favourable.

In the Aberdeen study a wealth of information was obtained about the relations between events in the mother's life history and obstetric history, specific experiences in the life of the child, and the child's mental status at school age. These findings lead the authors to conclude that mental subnormality is

not a problem which can be effectively approached by any single scientific discipline working in isolation. The most rapid progress will occur as the result of interdisciplinary inquiries which can, in depth, analyse the interaction of biological, social, and cultural factors affecting the growth and development of both normal and subnormal children.

Replication in different social settings is desirable.

I have perhaps dealt at tedious length with epidemiological research because the differences which are so clear in respect of it are less easy to see but no less important in comparative sociological studies concerned with services and with organizations.

RESEARCH ON SERVICES

That we can undertake research into the actual functioning of services is an idea which first came to be widely appreciated through the operational research which was started in the Second World War. However, it is only during the last decade or less that the belief that health services are subject to evaluation has begun to catch on. On the face of it, it would seem highly probable that some forms of social organization would be able to meet their objectives better than others. But whereas

until only a few years ago services developed solely as a result of experience, and were changed only as a result of intense dissatisfaction leading to Royal Commissions or Committees of Inquiry, today we seek evidence on which to base changes in our services. The plea for empirical study was well put by Barbara Wootton (1962):

Information is the raw material of social policy; but the problem is to get it intelligently used, and to replace obsolescent methods by the more effective techniques now available. Outstanding among such obsolescent instruments is the traditional procedure of Royal Commissions or similar committees of enquiry. Up till now these bodies, with one or two notable exceptions, have shown themselves more than a little conservative in their conception of how to set about their tasks. Typically, a Royal Commission proceeds by taking evidence from, and asking questions of, persons who are supposed to be knowledgeable in the particular field under review. This practice is apt to produce a rich crop of opinions, but a pitifully small yield of fact. At the best it needs, in nearly all cases, to be supplemented by direct first-hand investigations. . . . At the worst it results in recommendations as to policy being based upon second- or even third-hand material. . . . The Wolfenden Committee on Homosexual Offences and Prostitution heard evidence from such respectable persons as the Rt. Hon. Viscount Hailsham, QC, and the Lord Chief Justice of England, and from such bodies as the British Social Biology Council, but seems to have made no systematic investigation into the lives and problems of the persons most directly affected by the laws on those subjects.

Yet the extraordinary thing is that when we examine the attempts that have been made at evaluation of services, or of methods of changing the behaviour of individuals, we find that it has proved quite remarkably difficult to establish anything which stands up to scrutiny. Most of our cherished beliefs turn out to be without empirical foundation. Since I myself work in an Institute of Education, and not in the field of medicine, it is politic to choose examples from educational rather than health service research. Here then are a few common beliefs of educational or psychological signi-

ficance which are widely held but which have not been empirically demonstrated to be true.

It would seem obvious on the face of it that going to a nursery school would give children a better start in infant school and junior school. It would seem equally obvious that a programme such as Headstart would be especially beneficial to disadvantaged children from minority cultures. In ordinary schools one would expect the size of class to make *some* differences to children's progress, smaller classes being more effective teaching and learning situations than larger ones. Handicapped children, one might think, would be better educated in special schools, or classes, with specially qualified teachers, rather than in ordinary classes where the numbers are larger and the teachers not specially trained to meet their special needs. Some *methods* of teaching reading must surely be better than others. There must surely be demonstrable differences in the behaviour of children who have been subjected to different types of discipline in school. Would one not expect to find marked differences between the results achieved in schools with streamed and unstreamed classes, and between educational establishments which are run on comprehensive lines and those in which children are graded by ability and progress.

All of these matters, and many more, have been examined in recent educational studies, and the results are almost uniformly discouraging. For the most part differences simply do not emerge, or if they do they are so small as to be educationally trivial even though perhaps statistically significant. One is left with the uncomfortable feeling that the results of most of the evaluative studies that have so far been carried out are simply incredible. They just do not make sense.

What then can be going wrong in all this flurry of evaluation? In each of the examples I have mentioned there are of course specific factors which influence the outcome of evaluative studies – and it must be added that some of the no-difference sceptics are people who would deny that there are differences between

men and women or between President Kaunda and Mr Enoch Powell. But there is more to it than that, and throughout the long series of evaluative failures, if I may call them that, there runs, I believe, a common methodological shortcoming. Evaluative studies have persistently failed to look at the *quality* of what they are evaluating, expecting to find that forms of organization, or methods of teaching, or the numbers of children in a class, or the simple fact of being at school, or whether corporal punishment is used or not, are the real determinants of behaviour, as measured by educational achievement, or success at the 11 plus or at O level. The massive survey, which has now become the standard method of social research, rests on the assumption that if you have enough cases, differences in quality will somehow even out. Therefore they can be ignored; and since it is easier to collect superficial information from a dozen or a hundred different sources than to analyse processes in three or four, qualitative investigation has become unfashionable.

Let me quote Claude Bernard to put the opposing point of view:

In scientific investigations minutiae of method are of the highest importance. The happy choice of an animal, an instrument constructed in some special way, one re-agent used rather than another, may often suffice to solve the most abstract and profound questions. Every time a new and reliable means of experimental analysis makes its appearance, we invariably see science make progress in the questions to which this means of analysis can be applied. A bad method or a defective process of research may on the other hand cause the gravest errors, and may retard science by leading it astray. In short, the greatest scientific truths are rooted in details of experimental investigations which form as it were the soil in which these truths develop (Bernard, 1865).

If we pause to consider the matter it is extremely unlikely that purely formal studies of, for example, methods of teaching will lead to definitive results in favour of one or other type of instruction. What seems more likely to give results are studies which look at what

actually goes on in classrooms. So with the organization of services. Studies which have to do merely with the size of schools or hospitals, or with the numbers and training of staff, or with the age composition of patients in a ward, or the number of social workers in a community, without asking what these people actually do and how they do it, and why they act in one way rather than another, and what can be done to bring about change, have somehow failed to define their problem. They regard numerical analysis as a substitute for functional analysis: but the two are complementary.

It may be asked whether we have the 'new and reliable methods' of social science which caused the biological sciences to make progress and whether we can afford to spend time on 'minutiae of method' when great problems are crying out for solution. I think we can and must.

Fortunately social and behavioural science already has a very useful set of new and reliable techniques which can be employed in functional and comparative studies. Usable measures, of known and establishable reliability, already exist for the assessment of many personal qualities – not only of intelligence and educational achievement, but of neuro-integrative development, of language competence, of educational and social skills, of behavioural dysfunction and psychiatric disorder. Operational assessments of the number and quality of staff/patient interactions are already feasible, using highly reliable methods which discriminate sharply between different types of social establishment. Methods for describing power structures, organizational goals and institutional complexity are beginning to be developed. Analyses of function, at different levels of organization, of the factors which determine differences in function, and of the effects of such differences, are now feasible; and the urgent task of those who are concerned with health service research today is to press on with studies of this sort. Hence, though comparative studies across cultures are premature, functional studies within institutions or cultures, if carried out

with that concern for the detail of scientific investigation to which Claude Bernard called attention, are capable of replication. The results of such replication, whether concordant or discordant with what has gone before, will in themselves be the starting points for further explorations which will contribute to the understanding, and hence to the improvement of our services.

To stop here would be to deny what Hargreaves clearly saw as the most important role of an international organization – its educative function. At a time when many Sections in WHO were instituting model services in South East Asian villages, or calling together experts to discuss the latest in this or that, the Mental Health Unit pioneered the expert committee, the international seminar, and the system of travelling Fellowships. The importance of the results can scarcely be exaggerated. Hargreaves introduced to an international audience such men as T. P. Rees, Duncan MacMillan, Leslie Hilliard and John Bowlby. Their impact on international psychiatry was enormous, and its effects continue to be felt.

There is time for an illustration of the effectiveness of this type of educative work in mental health service planning.

This is how Ernest Gruenberg (1967), the coolest and most sceptical of American psychiatrists, describes the effect of meeting British colleagues at an international seminar:

My first exposure to the reformers' viewpoint was at the 1954 Toronto International Seminar. Dr T. P. Rees from England stated quite casually that his hospital had totally given up locked doors and all forms of physical restraint, and had done this prior to the introduction of the new tranquillizing drugs. As a psychiatrist who had begun work in mental hospitals in 1940 and with experience at St Elizabeth's Hospital in Washington with patients in disturbed and chronic wards, I recognized that he advocated less indiscriminate use of locked doors and physical restraint – a cause which certainly needed advocating from my point of view. He seemed to be using extreme statements to gain attention to a worthy reform. But others, whose opinions could not be ignored, told

me that I had completely misunderstood Dr Rees, that he meant literally what he said and that it was literally true. They said he was correct when he stated that severely disturbed behaviour had become very rare and that when it did occur, almost always in a newly admitted patient, it was short-lived. They also claimed that chronic withdrawal had become a rarity in patients who had first been hospitalized since this type of open hospital-community-based psychiatry was in effect. A few other hospitals in Britain had travelled the same path, and perhaps even further...

Not very long afterwards my colleague, Dr Robert C. Hunt, was awarded a WHO Fellowship to study these community-based psychiatric services in England. He approached the matter skeptically, like myself: sympathetic to the intent, but doubtful of the reality... Hunt visited Warlingham Park, Dingleton, and Mapperley Hospitals. As an experienced hospital psychiatrist he knew all the tricks for impressing visitors with an appearance of neatness and order and complete control. But he came away convinced that the absence of new cases of chronic withdrawal, of violent and disturbed behaviour, was genuine. The nature of the patients' behaviour in the severe

psychoses was markedly different from his prior experience. Dr Duncan Macmillan in Nottingham was most successful in making the methods used understandable to American psychiatrists. Hunt was so impressed that he came to the conclusion that Englishmen just don't go crazy the way Americans do. He had to be taken to a more old-fashioned hospital to be convinced that Englishmen too become assaultive, self-destructive, abusive, withdrawn, and excited.

In making such meetings possible, and in selecting influential and persuasive people from different countries to lead discussions to which other key people were invited, WHO was able to have an influence on psychiatric practice out of all proportion to the size of its mental health unit, or its budget. Though he sometimes made mistakes Hargreaves was particularly skilled in the choice of the experts he collected to lead such discussions, and it is through these, and the Expert Committee Reports, that he will be most widely remembered by people from many countries in the world.

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Towards a unified theory of human aggression

BY LEONARD S. ZEGANS*

More than a decade ago Camus remarked that 'murder is the question of our day' (Camus, 1956). In the years which have followed it has become increasingly clear that our fate both as individuals and as a species depends upon our ability to understand and control our aggression. A unified theory of human aggression must confront the problem of man's complexity. Man cannot be seen as a simple mechanism reflexly responding to fixed biological drives or environmental demands. Yet there is a tendency among some investigators to reduce the cause of aggression to some single explanatory principle, such as 'aggressive instinct', 'territoriality' or 'frustration' (Lorenz, 1966; Ardrey, 1966; Dollard, 1939).

The fundamental issue dividing most theorists today focuses on whether human violence is instigated and directed by innate, self-stimulating mechanisms or by social learning and environmental stimulation. To posit an endogenous, self-stimulating drive which triggers human aggression may lead to both philosophical and therapeutic pessimism. Freud once wrote: 'For the moment we must bow to those superior forces (destructive instincts) which foil our efforts' (Freud, 1937). Others who account for aggression as a product of social learning take a more sanguine attitude:

There is no such thing as a simple instinct for fighting... This finding has important theoretical implications because it means that under proper environmental conditions an animal is not driven to fight, nor will he suffer from emotional disturbances because of repression (Scott, 1958).

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In reviewing observation from many fields of science we will inquire whether either of these positions is firmly supported by meaningful evidence. At the conclusion of this paper, I will attempt to outline a model of human aggression which takes account of the interplay of genetic, familial and cultural influences upon man.

DEFINITION

One of the problems in understanding the phenomenon of aggression is the inconsistent use of the term. Psychiatric authors tend to be unclear in their definitions of the term. It has been described as (a) an internal state of anger; (b) an impulse or wish to be destructive; (c) overt acts of destruction, or (d) assertion of mastery over people and objects (Flügel & Lewis, 1948). Psychologists and biologists are more precise in their definitions. Bronfenbrenner & Ricciutti offer a definition which permits wide applicability for the clinician without sacrificing operational specificity. Aggression 'subsumes any action, thought or impulse the presumed aim of which is physical or psychological injury either real or symbolic to an individual or his surrogate' (Bronfenbrenner & Ricciutti, 1960). The authors do not consider such acts as a child knocking down blocks or cutting up clay figures as aggressive if this behaviour represents characteristic modes of manipulating material and does not reflect an impulse or intention to hurt or injure. This definition clearly avoids any implication of a homology between violence and assertion while taking into account man's ability to fantasize and displace his aggression.

ZOOLOGICAL APPROACHES

It has become fashionable to support or refute the notion of man's instinctive drive to aggression on the basis of animal observations

and experimentation. Zoologists generally accept the idea that fighting between members of the same species is almost universal among vertebrates from fish to man (Carthy & Ebling, 1964). Animals living in the same niche in nature must compete for food, breeding sites and mates. Fighting can serve an adaptive function by preventing overcrowding through dispersing animals over a wide area thus conserving vital resources. In many species, fighting or dominance behaviour among males ensures that fertilization of the female will most often be accomplished by males possessing the attributes of large size, courage or confidence. Most fights are 'no more than trials of strength followed by disengagement and rapid withdrawal by the weaker' (Lorenz, 1964). Ritualized threat and submission gestures, dominance hierarchies and territorial defence are nature's ways of assuring that intra-specific fighting does not end in death or mutilation. Lorenz contends that such important behavioural devices cannot be left to the hazards of individual or group learning but are controlled by innate mechanisms. He believes that genetic factors tune the animal's perception to specific environmental cues signalling aggressive intent; regulate the pattern of motor responses; fix the cues that determine the 'cut off' of attack behaviour; and set the threshold of internal motivation for attack. With ascent up the evolutionary ladder genetic control over these components (sensory, motor and motivational) shifted; motivational imperatives remain operant in higher species while innate motor and sensory mechanisms atrophy. It must be remembered that in each species the form, timing and lethality of aggression is adopted to its particular ecological needs. Cross-species generalizations about the function of aggression must be linked to specific information about the evolutionary role of this behaviour in each of the animal groups being compared. Inferring human models of aggression from analogies to fish or geese as Lorenz or Robert Ardrey have done can be inaccurate and misleading.

Lorenz believes that man is subject to many of the same internal motivations as other animals without the benefit of those instinctive mechanisms which modulate the intensity and form of their attack. His view of man's innate aggressive potential rests on the dual assumption that behavioural characteristics can be genetically transmitted and that man shares with the animal kingdom an endogenous mechanism for elaborating 'aggressive energy'. This 'central' accumulation of energy leads to attack either in the presence of an appropriate external releasing stimulus or spontaneously if such a trigger is long withheld. Many biologists regard this 'endogenous' system as an artificial abstraction having no correspondence to real physiological mechanisms but existing as the 'reification of hypothesized mechanisms' (Lehrman, 1953). Scott denies the existence of endogenous mechanisms spontaneously triggering aggressive behaviour: 'The important fact is that the chain of causation in every case traces back to the outside. There is no physiological evidence of any spontaneous stimulation for fighting arising within the body' (Scott, 1958). Other biologists take the more moderate stand that genetic influence upon primate and human aggression is limited to providing the neural, endocrine and motoric apparatus which elaborates the affects of anger and rage which themselves set in motion appropriate attack patterns. Marler and Hamilton deny endogenous causation of aggression but feel that innate influences sensitize the animal to certain classes of external stimuli (Marler & Hamilton, 1966). DeVore & Hall conclude from their primate studies that learning is necessary for all specific, meaningful connections and modifications to be made in the built-in forms of the behavioural repertoire (DeVore & Hall, 1965).

Primate evidence has been frequently used by Ardrey to support the claim of a dominance instinct and territorial urge in man though it is by no means certain that such behaviours exist universally among all species of monkeys and apes. Howler monkeys and mountain

gorillas show scant evidence of dominance relationships, while among the chimpanzee tolerance between males is in evidence during mating when several apes may copulate with the same female (Carpenter, 1934; Goodall, 1965). Dominance behaviour appears in those primate species which show marked sexual dimorphism, high group cohesion, sexual jealousy and competition, i.e. baboons, Indian rhesus monkeys. Primates lacking a strong dominance order tend to use flight as a means of predator defence while in dominance order species large, combative males protect the group against natural enemies. Except between predator and victim there is little evidence of inter-species fighting, and inter-group threat or aggression among animals of the same species tends to be rare. Primate groups tend to avoid each other if possible, affording scant opportunity for mutual attack.

Territorial defence is an important evolutionary mechanism controlling the aggression of certain species of animals. Territory refers to a geographical area to which the animal confines itself and from which it *excludes* others, particularly members of the same species (excepting its mate). These areas are defended by threat and fighting against sexual competitors. By isolating aggressive individuals within specified geographical areas actual fighting is reduced (Tinbergen, 1936). Wright has noted that territoriality is usually seen in mobile, lightly armed species (i.e. birds) where quarrels do not usually end in injury but in the escape of the loser to a new breeding site. It is questionable whether territorial behaviour is a constant feature of primate social organization. There are no reports of observations being made on such apes as the chimpanzee or mountain gorilla (Schaller, 1963, 1964). Carpenter has noted group defence of territory in howler monkeys and Washburn believes that territorial disputes between primate groups do exist though they are rarely reported. Wright has distinguished between territoriality and a 'fight for society' (Carpenter, 1934; Washburn &

Avis, 1958; Wright, 1942). An animal, though not urged by hunger, sex or territorial invasion, may react belligerently in response to the needs of the group of which it is a member. Such a societal war 'drive' may arise from the natural selective advantage of animal groups enjoying mutual aid, collective action and division of labour. Wright sees a positive affiliative instinct as the bond which provides the cohesion of animal groups. His theory suggests that any external threat to the cohesion and safety of the group can act as a strong stimulus to combat. Warfare in the interest of group cohesion is often seen in species that reveal complex social organization with differentiated fighting classes (i.e. man and ants). Such a social organization demands strong internal cohesion, good recognition of group members and quick arousal of hostility towards strangers.

Dominance and territorial defence as genetically determined modes of social organization have adaptive-survival value only for certain species. There is serious question whether these modes of social response were instrumental in the evolution of that primate line which culminated in *Homo sapiens*. Primate territoriality apparently discourages different groups within a region from congregating and interferes with interbreeding. It functions as a barrier to social integration, inhibiting complex group formation and role differentiation necessary for human cultural evolution.

EARLY MAN

Recent palaeontological findings are helping biologists piece together the scattered mosaics of man's prehistory. Our early hominid ancestors survived because they learned the use of tools and the advantages of cooperative, mobile hunting groups. When *Homo sapiens* finally emerged with his larger, more complex cerebral cortex a being appeared who could use language and symbols to create and communicate a tradition which linked past to present and could project ideas into the future. With the gift of language came another possession, in-

creased inhibitory neural control, new agonistic strings could be plucked and old modes hushed. Lorenz believes, however, that the development of speech and superior cognition caused *Homo sapiens* to lose the innate rituals which modified and softened the aggressive behaviour of his mammalian ancestors.

As a hunter, early man had to follow his game over considerable distances into new grazing areas. His behavioural system permitted him to adapt to a wide range of environmental conditions. Most territorial animals (including primates) live in very restricted home ranges. A strong attachment to a particular territory would have been maladaptive for those early hunters. Sahlins has commented:

Primate territorial relations are altered by the development of culture in the human species. Territoriality among hunters and gatherers is never exclusive and group membership is apt to shift and change according to the variability of food resources (Sahlins, 1959).

Vegetarian animals gather their food alone, adults do not even share with juveniles (Washburn & Avis, 1958). Pack-hunting carnivores are faced with the problem of bringing prey back to females and children who do not participate in the hunt. Success as a predator required major social reorganization in early hominid social life. A likely modification was the easing of the strong aggressive feelings and dominance bouts among males. The dominance system of vegetarian baboons and macaques exclude many males from the group, fostering bachelor subgroupings and sustaining an air of harassment and threat. This arrangement would have made cooperative hunting extremely difficult for early man. 'Compared to infrahuman primates, ranking hierarchies and dominance approaches zero among hunters and gatherers' (Sahlins, 1959). It would appear then that emergent man was endowed with a milder disposition to dominance and a weaker instinctive link to territory than his herbivorous ancestors. Though probably retaining some innate sensitivity to cer-

tain classes of stimuli which provoked anger and attack he could also learn an infinite variety of new cues to aggression. His enlarged brain permitted him to delay, detour or symbolically fantasize his aggressive discharge. Little adaptive purpose could be served by the inheritance of an endogenous, self-stimulating aggressive drive. Such an internal summons to combat would have retarded the difficult task of forging larger, more cooperatively differentiated social organization. Man's cerebral capacities offered him greater control over the timing and form of his attack yet he lacked the fine balance of engrained threat and appeasement gestures vital to the survival of his primate cousins. This deficit rendered him most dangerously plastic in the range of his aggressive potential.

ANTHROPOLOGICAL STUDIES

Field studies have given us some glimpses into the aggressive relations among existing primitive hunting tribes. Their history is not one of continued blood warfare. Neighbouring tribes usually achieve an equilibrium with one another and their physical environment, with war appearing as an unusual event. A change in climate, migrations or new types of economic techniques may shatter this peaceful balance. Intertribal rivalry when it does occur is often mitigated among many primitive peoples by the ritual of tournament fights which may take peaceful forms. Such fights have been recorded among Papuans, Polynesians and South American Indians. Eskimos have a tradition of public insult songs to avoid physical aggression, while the Punans of Borneo, pygmies of Africa and Australian aborigines have elaborated ritual systems which reduce physical violence among rival groups (Vayda, 1968). Malinowski interprets these facts to mean that primitive man does not desire bloody combat with his neighbours and protects against this by avoidance or ritual. Violence is seen by him as 'part and product of personality or of culture' and not as a vital impulse inherent in man or his society

(Malinowski, 1941). Margaret Mead has written that people go to war not because of biological urges or even social deprivations but because war is the way in which certain situations are traditionally handled within the culture (Mead, 1940).

War is rarely fought among peoples because of explosive growth of a population pushing belligerently into new territories. Plunder rather than population pressure triggered the invasion of Christian Europe by nomadic Aryan tribes. The endless feuds between Mesopotamia and Egypt, Persia and Greece, Rome and Carthage were fought between empires of competing ideology and interest, not peoples struggling for biological existence. The Chinese and Indians, though long plagued by burgeoning populations, have been among the most peaceful people on earth. Throughout history, war has served as an instrument in maintaining the cohesion of tribes or expanding the influence of national groups. 'The larger and more complex the group the more necessary war has appeared to be as an instrument for its integration' (Wright, 1968). The human thus appears unique among primates in that man will die for symbols and slaughter for abstractions while often ignoring the biological survival needs of his own people.

PSYCHODYNAMIC THEORIES

The work of a psychiatrist permits him to intimately confront the complexity of man's thought and behaviour and approach the problem of human violence from a syncretic perspective. Psychodynamic theories have taken into account more fully than others the capacity of man to fantasy and symbolize his violent wishes. They also emphasize plasticity of human aggressive expression facilitated by the multiple channels of substitutive gratifications open to man.

During his career Freud postulated three basic models for human aggression. First he considered that aggression was tied to the vicissitudes of man's *sexual energies*. 'The

child's violent love' for the parent of the opposite sex was accompanied by death wishes against the rival parent. Aggression was also identified as a component of the oral and anal phases of libidinal development. Freud then abandoned this concept, assuming instead that aggression was at the disposal of the *ego* for its purposes of preserving life and guarding the attainment of instinctual satisfaction. Clinical evidence suggested to him that the child reacted with aggression whenever an instinctual wish failed to be gratified or was deliberately thwarted by parental or environmental pressures. Aggression was not a biological phenomenon rooted in instinct but a social reaction to the stresses and frustrations imposed by the environment (Freud, 1923). This 'frustration model' was similar in broad outline to that of the Dollard-Miller group formulated at Yale in the late 1930s (Dollard, *et al.*, 1939). Freud ultimately abandoned this model because his clinical experience provided too many instances which could not be adequately explained by it. Academic psychologists also criticized the concept that aggression was the inevitable response to frustration (Buss, 1961). Both Freud and Dollard underemphasized the relationship between frustration and the intervening affect of anger. Frustration can be conceived as inevitably leading to some form of anger (chagrin, irritation, peevishness) but this emotion need not always lead to direct physical attack. Anger may lower the threshold to aggression but the prior experience of the individual might lead him to select a different response to this affect. Berkowitz argues that anger need not lead to aggression unless there are present appropriate cues or releasers favouring this behaviour (Berkowitz, 1958). Such cues themselves may not suffice if there exists a potent learnt inhibition over the direct expression of hostility (turn the other cheek). Anger clearly appears to be the most important affective precursor of aggression but is not an exclusive one. De Sade has linked aggression to sexual motivations, while Sartre conceived it as a response to existential anxiety (Sartre, 1968).

While modern authors such as Norman Mailer and Genet regard violence as a possible response to the boredom and meaninglessness of modern life, political writers like Débray and Fanon link violence to man's sense of exploitation and political powerlessness. Psychologists also remind us that much aggression is executed without any evidence of anger or frustration (McNeil, 1959).

Instrumental aggression is performed simply with a view to obtaining some desired object, space or condition. A person may learn that aggression is a convenient device for achieving some desired goal or internal state.

Freud's frustration theory was consistent with his belief that man's tendency to seek pleasure and avoid pain was his basic mental mechanism. In 'Beyond the Pleasure Principle' (1920) he repudiated the universality of these mechanisms and grouped the entire range of instinctive urges under the *life force* serving the purpose of preservation, propagation and unification of life, and the *death or destructive force* which served the opposite aim of undoing connexions and reducing life to an inorganic, motionless silence. Later ego analysts have dropped metaphysical trappings of Freud's theory but instead postulate an 'aggressive energy' resident within the id and capable of being neutralized or fused with sexual energy (Hartmann *et al.*, 1949). Thus conceived, man seems fated to contend with aggressive impulses even in the absence of significant frustration by reality.

Many theoreticians have criticized the concept of a qualitatively specific mental energy which gives direction to human behaviour.

From the standpoint of consistency, it is difficult to conceive of energy as directionally specific. When it is set free in nervous substance in the form of chemical and electrical changes, it is specific only in the sense that it is evoked by specific stimulation and in regard to the pathways or regions stimulated (Hinde, 1959).

It is difficult to see how an internal drive for fighting behavior could be adaptive, since it would result in both the individual and the species being unnecessarily put in danger. Agonistic behavior

primarily serves as an adaptation to external circumstances rather than to a universal need (Scott, 1958).

We must abandon innate drive and energy concepts and begin to trace the mutual influences of learning, affect and fantasy upon one another during individual development. Man's aggression seems to be related to the interaction between constitutional factors (thresholds for motor discharge, frustration tolerance) and his history of reinforcement for violence or restraint based on models provided by parents and peers.

The notion of a unitary and independent aggressive instinct powered by psychic 'energy' is being increasingly rejected in favour of a more complex model which considers the phenomenon from the multiple vantage of the neural apparatus, prevailing environmental conditions, ego structure and internal excitatory and inhibitory states. As Sandler has remarked:

There is thus a close relationship obtaining between drive and apparatus. What we normally understand by the sexual and aggressive instinctual drives are complex phenomena involving the whole spectrum of discharge characteristics and associated tensions and pleasures (Sandler & Joffe, 1966).

NEUROPHYSIOLOGICAL MODELS

Early in his career Freud attempted to explain psychological phenomena by drawing upon the neurophysiological models of his day. He soon abandoned this attempt, later framing his theories in purely psychological terms. He often expressed the belief that many of the problems of the mind would ultimately be unravelled by experimental biology. A review of recent work on brain mechanisms involved in the elaboration of aggressive behaviour does not support either Lorenz's or Freud's theories of endogenous aggressive 'energy'. Many neural networks appear to be integrated in the elaboration, inhibition and coordination of agonistic behaviour (Kaada, 1967). The hypothalamus plays a central eliciting role, but it is strongly

influenced by limbic, cortical, tegmental and reticular pathways. Threat, fight and attack have neighbouring or overlapping neural representation and the affective and motor components of aggression are anatomically dissociated, thus liable to independent inhibition or excitation. Through the interaction of forebrain and limbic centres cognitive and affective information can mutually influence the threshold, timing and form of the aggressive response. Hormonal influences may link the aggressive threshold to physiological events outside the central nervous system (Rothballer, 1967). Such a complex interlocking system of checks, balances and initiatives does not suggest a 'steam-boiler' mechanism which automatically builds up and discharges surplus aggressive energy. Instead, this system possesses the potential for flexible expressive, autonomic and motor discharge in response to a variety of environmental and bodily stimuli. The basic expressive and motor patterns appear to be genetically programmed into most mammalian neural systems but they can be modulated and altered to produce finely graded variations of the agonistic response. Certain stimuli (like pain) may provoke an unconditioned response of anger. The 'aggressiveness' of an individual relates both to the ease of anger elicitation in response to negative stimuli as well as the threshold of attack behaviour triggered off by the anger. Heredity must play a role in setting these thresholds, but evidence suggests that patterns of early infantile stimulation are also important. Rats stimulated early in infancy show faster maturation of the hypothalamic-hypophyseal-adrenal systems than non-stimulated animals and they possess a heavier subcortical brain with more rapid myelination of central pathways. Stimulated animals will also respond to novel situations with more effective, less emotionally disorganized responses. Animals separated from play-peers early in life or reared in more restrictive sensory environments tend to be more aggressive and emotionally labile (Levine, 1962). Such

work suggests that the conception of aggression as the result either of the discharge of an endogenous self-stimulating neural centre or as a learnt response to frustration is atomistic and unmindful of the complexities of individual human development.

AGGRESSION AS A LEARNT, SOCIAL RESPONSE

Many investigators believe that the socialization process is the most important factor in determining the expression and control of aggressive behaviour. Socialization involves teaching the child how to react to frustration in an acceptable manner. Bandura stresses that a physically punitive parent can set a model of aggressive behaviour for the child to follow which sanctions aggression as well as demonstrates for him how to be aggressive (Bandura & Walters, 1959).

Buss defines aggressiveness as a *habit* of attacking. He cites four determinants of aggression: (1) *Antecedents of aggression* (attack, frustration, annoyance, pain). The frequency and chronicity of these antecedents will determine whether a person will be chronically angry and thus more likely to be aggressive. (2) *Reinforcement history*. Frequent, strong reinforcement of aggression will lead to a strong attack habit, weak reinforcement leads to a slight habit. The reinforcement may be 'internal as in a sharp drop in anger; or it may be external as in the elimination of a noxious stimulus or the attainment of a reward'. (3) *Social facilitation*. The adult or peer group can 'facilitate' the development of aggressive personalities by providing aggressive models for the child to imitate; by supplying provocation to aggression and social reinforcement for aggression once it has occurred. (4) *Temperament*. This is defined as 'characteristics of behaviour that appear early in life and remain relatively unchanged'. The variables which can influence the development of aggressiveness are impulsiveness, intensity of reaction, activity level and independence (Buss, 1961).

AROUSAL AND AGGRESSION

An important temperamental characteristic which may be important for aggressive behaviour is the rapidity with which an individual habituates to novel stimulation. Some people habituate with extraordinary speed to new things or situations and after a period of brief interest lose complete interest. Hebb has remarked how man can seek excitation in undesirable ways.

children and young primates (at the Tavistock Clinic and Regents Park Zoo, London) have led me to identify two basic classes of aggressive behaviour. In one the child engages in aggression in order to increase his gradient of arousal. Such aggression often follows careful rituals of play-fighting; however, some individuals never learn the social modulation of play aggression so that their activity is unintentionally destructive or pain-producing. The most virulent variety of this class of

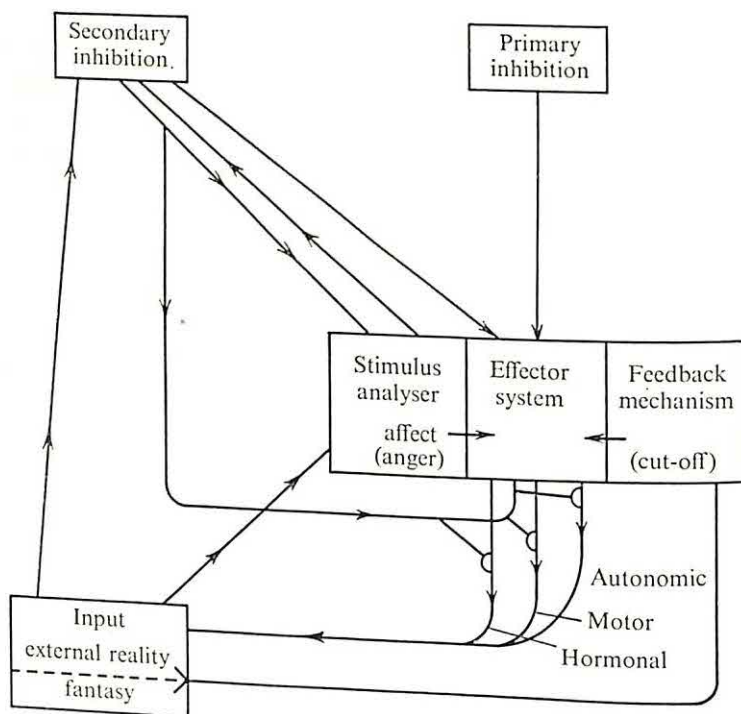


Fig. 1

The plain fact is that the primate is only too ready to become a troublemaker when things are dull and we had better stop comforting ourselves with the accurate but insufficient statement that man has no instinct to make war. He also needs no special coaching to discover a taste for adventure and some of his adventures may be socially disastrous... (Hebb & Thompson, 1954).

Certain children who exhaust the exciting potentials of a play-situation can become unexpectedly aggressive. Their attack seems to provide a steep gradient of pleasurable arousal. Observations of the fights and play of

aggression occurs when the feedback of inflicting pain acquires high pleasurable arousal value. The second major class is related to those behaviours which bring about a reduction in arousal. The individual finds himself in a highly excited state (due to pain, intrusion or frustration) and attempts to remove the source of undesired stimulation. Most nursery school children show admixtures of stimulus-seeking and stimulus-avoiding fighting. The motoric and expressive patterns of the child often differ according to the intended outcome of his aggression.

CONCLUSION

Evidence available from biological and psychological sources does not support the idea of an endogenous aggressive drive in man. Humans are not fated to express innate destructive behaviour, though we are genetically endowed with a neural apparatus which can generate aggressive responses. Our dilemma is not the repetitive discharge of aggressive energy but the promiscuous ease with which our mechanism for recruiting fighting behaviour can be triggered. Because of man's capacity for symbolic thought and prediction an event need not occur in reality for it to represent a potential threat; a hint, a movement can instigate a chain of fantasy leading to pre-emptive attack. Our aggressive responses can also become entrained by instrumental signals independent of frustrating or painful stimuli.

A model of aggression which seems most reflective of human experience would postulate an affective barrier between the provoking stimulus and the aggressive discharge (see Fig. 1). The 'aggressive apparatus' would require such a mechanism for determining what inputs mean on the basis of the past affective experiences of the individual. This *stimulus analyser* would elaborate internal feelings of anger or frustration when confronted with aversive cues received from peripheral receptors or elaborated by thought. If the affective signal is strong enough it may trigger the *effector* mechanism to fire. The effector subsystem would control the output of the aggressive apparatus, determining the nature of the response and its object. It can activate motor (including expressive) endocrine and autonomic pathways. In an infant or young child the motor component of this subsystem is incompletely developed so that damaging aggressive acts are unlikely. The effector mechanism can, however, activate the endocrine and autonomic channels even during this period of motoric immaturity. In adult life the capacity of the effector system to be fragmented into motor, expressive and

vegetative components continues. Thus anger may instigate an aggressive reaction which may include autonomic and hormonal responses but only minimal motor behaviour.

There does not appear to be any innate human consummatory response which automatically switches off the effector discharge. The model obviously needs a *feedback mechanism* which can terminate effector outflow. In some animal species there are genetically programmed acts (such as the wolf exposing his neck veins to the attacker) which will switch-off the assault. In man most cues terminating aggression appear to be learnt, i.e. victim crying, falling below eye level, displaying infantile behaviour. These behaviours instigate affects which compete with the emotions sustaining the attack. Certain affects may be innately incompatible with the continuance of violence in man (pity, shame). These affects are usually aroused by external events but may be elaborated in fantasy. Imagination may both instigate certain components of the effector response as well as effect its cessation. Individuals will certainly differ in the degree to which their effector systems are 'tuned'. Some may emit a strong aggressive discharge after only a weak signal of anger transmitted from the stimulus analyser. The threshold of effector response will be determined by the strength of the affective signal it receives, its own 'inertia' and the inhibitory influences which play upon it. I believe that integral to the functioning aggressive 'apparatus' is a *primary inhibiting* subsystem which exerts a tonic restraining effect upon the effector mechanism. This inhibiting mechanism is part of the basic developmental endowment of the human and does not depend upon social learning to operate. Neurophysiological experimentation suggests that such a structure is disrupted by cortical ablation or insult (Bard & Mountcastle, 1947). Thus in man the strength of this inhibitory control is likely to be adversely influenced by congenital brain defects, cortical injuries, and such transient conditions as fatigue and intoxication.

The *secondary inhibitory* mechanism, however, is dependent for its function upon the social experiences of the developing individual. It is a precipitate in the psyche of the past negative reinforcements and value introjects of the person. It represents the influence of the family and society upon the instigation of aggressive behaviour. Secondary inhibition operates by controlling the timing and direction of aggressive output. It can change the direction or aim of the motor component but *not* eliminate some discharge from occurring. Thus the object of the aggressive attack can be altered (displaced or internalized) or the mode of expression changed entirely (sublimation). The motor discharge may be inhibited while the endocrine and autonomic response continue to be evoked. It is possible that when motor and expressive elements are withheld from the effector response that the vegetative discharge alone cannot elaborate an effective cut-off signal. If the provoking stimuli continue to operate (in reality or thought) then there may be serious psychosomatic consequences since the body is placed under continued autonomic stress. Secondary inhibition may be also responsible for the anger reaction being withheld from consciousness. Thus the individual would have no way of checking his emotional response against a re-examination of the eliciting stimulus situation.

For centuries mankind has attempted to use secondary inhibition as its dominant means of checking its destructive potential, but with pitiful success. Perhaps there is now a need for

us to consider a *third* form of control over our aggression. This would involve a reinterpretation and change in those signals that provoke our rage rather than a blocking or redirection of our violence. Aggression will remain the 'issue of our day' as long as poverty, discrimination and exploitation supply men with chronic and realistic cues for their anger; and society sanctions the use of violence as a means of securing pleasurable arousal or power. We must remove these goads to rage as well as stop conditioning our children to fear new and unfamiliar ideas and life styles.

If our lives are to be more purposive and peaceful, then human thought, the building block of man's evolution, must become more unified and yet more diverse. Unified, in that any communicative isolation and fear between centres of thought upon earth must not be tolerated. And more diverse, by encouraging expression of varied and unique ideas, those mutant genes of humanistic imagination and growth. Gradually under the threat of nuclear war, environmental pollution and the collapse of parochial social institutions, men are beginning to realize that they are part of a species whose survival depends upon mutually cooperative actions. Individual and nationalistic strivings can no longer be culturally sanctioned and rewarded if they are isolated from efforts to protect and enhance our species and its supporting ecosphere. Perhaps then we need not look backwards to our animal ancestors for instruction in how to avoid the self-destruction of the human race.

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Some uses of a psychoanalytic point of view in the diagnostic assessment of childhood disturbances*

BY CLIFFORD YORKE

All those who work in child guidance clinics, child psychiatric departments in general hospitals, and other relevant agencies are too well aware that the diagnostic assessment of psychological disturbances in childhood bristles with difficulties. The questions which present themselves on referral are as various as they are sometimes baffling; and even the simplest and most familiar of them calls for careful consideration. We should like to know, when a child appears in difficulties, whether these are simply reactions to a particular family or social context; whether the child can be considered disturbed in his own right, irrespective of any other family circumstances or pathology; whether such a disturbance is a product of a developmental stage – a developmental strain, as Nagera (1966) called it – which can be expected to be outgrown once that stage is negotiated; or whether the disturbance is still *in statu nascendi*, where, without appropriate intervention, comparatively minor presenting symptoms may well assume a greater import and gravity. And while too few of these questions are answered quickly or easily, we know all too clearly that, without some reasoned assessment, we are equally without any guide to treatment or prognosis.

Whatever psychological school or orientation to which we subscribe, there would perhaps be general agreement on the usefulness of a conceptual framework to which we can refer our diagnostic thinking. Such a

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framework is in no way superordinate to our customary methods of investigation. It should not impose itself on the information or material at our disposal, nor can it ever be a substitute for clinical judgement. It is at best a servant and not a master. It is no more than a conceptual tool, a guide to our diagnostic thinking; and we should not hesitate to modify it whenever clinical circumstances and experience reveal its limitations and shortcomings.

For some years now, the Hampstead Child-Therapy Clinic has used such a conceptual framework. This has been described by Anna Freud (1962). Unfortunately, its discussion in the literature is largely directed to practising psychoanalysts, but its usefulness may be such that its basic principles are of some interest to a wider audience. The framework is based on the structural model of the mind* propounded by Freud as long ago as 1923, though it takes account of some of the developments and modifications made to those formulations in the intervening years. It may be useful to begin with a brief restatement of some of the principal propositions concerned since, although in many respects these are well known, such a recapitulation may also provide a background for the papers which follow by Rose Edgcumbe, and by Anne Hurry and Joseph Sandler, and which are also based on the advances in psychoanalysis deriving from the structural model.

*The structural model must be distinguished from what is generally known as the *structural point of view* – the latter represents only *one* way in which any mental event can be regarded. Freud, from 1915 onwards, held that other points of view, such as the *dynamic* and *economic*, should also be taken into account. All such points of view are, however, possible within the framework of the *structural model*.

THE STRUCTURAL MODEL

The structural model of the mind is no more than a convenient way of conceptualizing the human personality in terms of major, inter-relating, psychic structures or agencies. It makes no attempt to answer such age-old questions as the nature of mind. It is a model, and to that extent an aid to conceptual thinking.

The agencies with which this model is concerned are familiar to us as the id, the ego, and the superego. Of these agencies the *ego*, perhaps, has first claim on our interests. The term 'ego' appears in the literature in a variety of guises, and Freud himself sometimes used the term ambiguously. For present purposes, it will be taken to mean *the executive apparatus of the mind*; and it should not, therefore, in spite of common usage, be confused with such concepts as the 'self' (Hartmann, 1950). Seen in this light, the ego's main task is to act as a mediator between the frequently conflicting claims of the other psychic agencies – the id and the superego – as well as external reality. If, for present purposes, we consider the adult ego, we would largely assess its degree of maturity, its strength or its weakness, in terms of the efficiency with which it discharged this task. But perhaps such a statement anticipates an important part of the argument; and it may be useful to say a few preliminary words about the other psychic agencies.

Freud conceptualized the *id* as comprising those powerful, energizing forces, *the instinctual drives*, as well as their psychic representatives. Such drives have sexual and aggressive aims, though these aims are subject to modification through the intervention and activity of the ego. It is hardly necessary to emphasize the complexity, variety, and plasticity of the drives, especially the sexual ones; their ultimate roots in somatic sources and tensions; and their peremptory nature which, if unchecked, would invariably lead to gratification through discharge. As early as 1905 Freud described how the adult drives retain imprints of their

earlier history, so that a genital drive which culminates in sexual intercourse may also indulge a number of component, antecedent, but still co-existing drives in sexual foreplay. One task of the mature ego is to contain these drives and control them, allowing their discharge only where this is appropriate.

The concept of the *superego*, to which we must now turn, has gained in complexity over the years, though it still retains and includes its original meaning. It refers to those mental representations, mainly of the parents, internalized by the child during the course of development, and which continue to function within the mind as permanent, structural, and, to some extent autonomous, agencies. These internalized sources of morality govern, with varying degrees of permissiveness or interdiction, the individual's standards of behaviour; but, since the parents are not only sources of authority and moral precept, but also, for a considerable time, the principal bearers of affection and esteem, the superego also includes internal representations which, once they become independent, continue to furnish important and necessary supplies of self-love, self-regard, and self-esteem. In summary, the superego is an internal source of demands on the ego which must largely be met if guilt is to be reduced to tolerable levels and adequate self-esteem preserved.*

It follows that the claims of the instincts may, at any given moment, conflict with the aims of the superego, so that the claims of the one may have to be met at the expense of the other; or result in postponement of a desired course of action or even its abandonment; or result in compromise; and so forth. But as soon as we consider discharge in action, or try to discuss the fulfilment of instinctual aims, we realize that the ego has still to take account of yet a third taskmaster: namely, *external reality*. And since adaptation necessarily includes adaptation to *external* as well as to *internal* demands, we realize that it is primarily *adaptation* with

* For a fuller account of some of these matters see, for example, Sandler (1960).

which we are mainly concerned. The *ego* is, above all, the adaptive agency of the mind, as Hartmann (1939) consistently emphasized; and it is, perhaps, for this reason that the *ego* has, for so long, loomed so large in our psychological concepts. It is through the *ego* that internal wishes and needs can, with due regard to internalized standards of behaviour, meet the claims of external reality while, under favourable conditions, at the same time achieving harmonious gratification and expression.

At this point it is convenient to summarize, however briefly, these varied functions of the *ego*. In relation to the *id*, we can point to the *ego*'s unconscious operations of defence, by means of which certain drives and their derivatives are not only denied direct expression but, in certain circumstances, excluded from consciousness altogether. The efficient use and organization of defence plays an essential part in harmonious mental functioning.

Nevertheless, an important and related function of the *ego* is to allow the appropriate discharge of sexual and other instinctual wishes wherever these are consonant with accepted desires and behavioural standards. To this end, the mature *ego* is able to postpone gratification until circumstances are judged to be appropriate. It must therefore take account of reality. To quote Freud (1923):

By virtue of its relation to the perceptual system it (the *ego*) gives mental processes an order in time and submits them to reality-testing. By interposing the processes of thinking, it secures a postponement of motor discharges and controls the access to motility.

It follows, then, that the *ego* may actively seek to re-order and change reality in order to gain acceptable instinctual ends. This is impossible without the exercise of such complex functions as intellection, memory, judgement, and the control of skills.

Lastly, the *ego* is responsible for the organization of its own mental content, from the most primitive memory-traces to the most elaborate sense-data, into self- and object-repre-

sentations. In this way, a picture of both inner and outer world is built up and given shape and cohesion.

There are certain other matters which seem important in considering, for present purposes, the use of the structural model. The first concerns *anxiety* (Freud, 1926; A. Freud, 1936). It is generally accepted that the *ego*'s adaptive functions may be endangered from any one of three sources. In the first place, it may be threatened by a real external danger. It may then be the focus of what has been called *realistic anxiety*, and thereby be prompted, in its executive function, to take appropriate action – in Cannon's classic phrase: 'fight or flight'. Secondly, it may be threatened by an undue power of instinct, by forces of such magnitude that its capacity to resist them may well appear in jeopardy. In such a case, we may properly speak of *instinctual anxiety*. As with external sources of danger, it is not difficult to think of familiar examples. An *ego*, for instance, which has satisfactorily contained or mediated the drives of latency, may be faced with comparative helplessness when biological reinforcement of the drives occurs at puberty. Thirdly, and lastly, a harsh and punitive superego may sometimes exert pressures on the *ego* which may border on the intolerable. Here it would be logical, or at any rate consistent, to refer to *superego anxiety*, although, in practice, we tend to use the more familiar synonym of 'guilt'.

CONFLICT

We have seen that anxiety, however occasioned, is a signal in the *ego* which points to a threat or danger. Whenever such a danger stems from the outside world, the *ego* must choose between *avoidance* or *conflict*. There is, unfortunately, no such choice when the *ego* is threatened with a danger from inside. Conflict inevitably ensues, the outcome of which will largely depend on the strength of the *ego* itself. Where this is unequal to the pressures put upon it the *ego* may have to give way; and it is precisely this kind of situation which

occurs when an instinctual impulse erupts dramatically and overcomes all resistance. In adults, we need only think of an unpremeditated *crime passionnel*, or those many instances for which the law reserves the finding of 'diminished responsibility'. Fortunately, in young children the outcome is often less drastic, though impaired ego control, if persistent, may well be a cause for concern.

More commonly, the ego is threatened by the conflicting claims of the superego on the one hand and the instinctual drives on the other. It may not be able to accommodate such pressures without some form of compromise. In such circumstances the ego is at the heart of a conflict which can properly be called *internalized*. A brief example may not only serve as an illustration but may also exemplify the fact that conflicts themselves have a history in which their relationship to the ego may have undergone important changes. In a young child, we would be justified in considering a battle with the mother over, let us say, toilet training, as an external conflict. But, at a later stage, the superego, now functioning autonomously, may take over the parents' role and exert a measure of *internal* control over residual wishes to mess and soil. In short, a conflict which was hitherto external now operates as if it were wholly within the child.

So far we have considered conflict as it occurs between the major structural agencies of the mind as well as in relation to external reality. We must also raise the question of whether conflict can arise *within* structures as well as *between* them. Within the id, psychoanalysis has long recognized the *potential* conflicts between activity and passivity; between masculinity and femininity; and between love and hate. The superego, too, may have paradoxical aspects; in certain conditions, among which we may number some forms of drug addiction, it may be both permissive and prohibitive at one and the same time (cf. Simmel, 1929). As for the ego, many psychoanalysts – notably Hartmann (1950) – have pointed to conflicts within that structure. Denial, for example, may have a defensive

function which fosters internal harmony; but by, in certain cases, interfering with reality perception, it may seriously disturb a different, but equally important, adaptive ego function.

THE PSYCHOANALYTIC PROFILE

We must now turn to the application of some of these psychoanalytic principles in the work of diagnosis in children. Some years ago, therapists working at the Hampstead Clinic expressed dissatisfaction with the diagnostic case conferences as they were conducted at that time. The procedure hitherto followed was very much as elsewhere; the psychiatrist, psychologist and social worker presented their reports and impressions as a basis for free discussion. It was now suggested that the relevant material be distributed and read by participants beforehand; and that the ensuing discussion be structured in accordance with the psychoanalytic frame of reference, and the ground prepared for a more fruitful diagnostic formulation than was sometimes reached by traditional dialectic. Out of these early discussions Anna Freud's Diagnostic Profile was born; and it has been in use, with subsequent modifications, ever since. As far as I know it remains the only thoroughgoing attempt to put psychoanalytic theory firmly and systematically at the service of diagnostic assessment.

Essentially, the profile is a form of assessment of the child's personality which tries to take proper account of both external and internal factors in his life as well as the interactions between them. Attention is directed to the child's social and family environment, the personalities of his parents, and their relationship to each other as well as to the child. Essentially, we need to consider, as far as we are able from our limited information, the many factors which may contribute to his total personality and the ways in which they interact with one another. It is at this point that the usefulness of the structural model may become apparent.

This implies that we assess in turn the in-

fluences which the different mental agencies appear to bring to bear on the ego; the quality, the level of organization, and the nature of the ego itself; and the way in which it responds to the pressures with which it is faced. We would need to assess the level of the child's drive development in accordance with available information about the various derivatives and expressions of drive activity. It would seem helpful to estimate how far such drives were under adequate control; to what extent they assisted or hampered the ego in its task of coping with external reality; and the cost to the mental economy of the maintenance of pathological or atypical defensive formulations and manoeuvres. Since the drives generally relate to objects, we would want to gauge the nature and quality of object-relations; and since the self too is an object of instinctual investment, any appraisal of the latter would have to include the self as an object in its own (and very special) right.

Furthermore, we should be obliged to think of the superego in terms of its developmental level, its degree of autonomy, its efficiency, and its maturity in its crucial role as an internal source of both moral standards and self-esteem. A primitive, harsh, and punitive superego which constantly provoked excessive guilt could hardly be considered either mature or efficient and might well hamper, rather than assist, both internal and external adaptation.

Of all these aspects of the personality, the ego itself may present us with the most complex and difficult part of our assessment. For we have to consider the efficiency with which the ego discharges its perceptual, intellectual, motor, and other adaptive tasks; to see how far such functions appear to be interfered with by the impact of other aspects of the personality, or even by other ego activities such as defence organization; to take note of its integrative functions in holding the personality together; to say something of its capacity to experience and tolerate anxiety as a warning signal without being overwhelmed by it; and to assess its capacity to

endure frustrations and to tolerate, and cope with, a variety of affective states.

These points may serve as indicators of the kind of personality assessment at which the profile aims; though in practice we are constantly hampered by limited information and innumerable points of uncertainty. The diagnostician need not be afraid to acknowledge such restrictions. Nevertheless, he will try to say something about the child's symptomatology in the light of his formulations, however incomplete these may be, and to assess, for example, the stage of development at which symptoms have originated. In the case of obsessional symptoms, for instance, he will often find that drive development lags behind a precocious ego and superego development. It will sometimes be possible to see where, within the personality structure, the symptoms are localized; and with any luck to detect, with varying degrees of precision, the external influences and mental processes which have made their varying contributions to symptom-formation. Traumatic events (such as deprivations); developmental arrests; regressions of id, ego or superego; anxieties wherever these are excessive; defence activities; and the principal conflicts contributing to pathology would be noted whenever this was possible.

Assessment by profile, then, may be of practical value in achieving more accurate diagnosis and in giving some indication of prognosis and possible management. Recently, Anna Freud (1970) has given examples of how this can work in practice. *Lying*, for example, may prove to be a simple developmental phenomenon when the ego's ability to distinguish between reality and fantasy has not been fully achieved. Such a state of affairs may or may not be age-appropriate. But lying might equally well be shown to stem from excessive parental pressures with resulting fears of punishment. *Bedwetting*, when not organic, may be due to parental neglect; to general inability to achieve impulse control or to play its part in an infantile neurosis and retain a symbolic meaning. Lastly, *school failures* may be associated with delays, arrests, or regres-

sions, whether organic or not; with inadequate stimulation from home and parents; or from neurotic interference.

Finally, it must be emphasized that the profile, and the structural viewpoint it embodies, is not meant to present a child's disturbance in terms of some artificial formula divorced from the richness and complexity of life. By trying to understand the interplay of forces which contribute to the child's development, we would hope to be able to understand more clearly a living relationship between inner and outer worlds.

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A consideration of the meaning of certain types of aggressive behaviour*

By ROSE M. EDGCUMBE

I take as my starting-point the notion, sometimes explicitly stated but more often left implicit, that it is desirable for aggression to be openly expressed. I have in mind clinical discussions which I have attended in which heated arguments have raged over whether children should be encouraged to 'express their aggression', or whether they should be taught to control it. I have more than once been dismayed when visiting departments of child psychiatry and child guidance clinics to be shown rooms bristling with toy weapons and suitable materials for making messes, and to be told with pride that here the patients can let out their hostility and anger. My dismay is due to a suspicion that such attitudes are based on certain mistaken assumptions.

Among the assumptions which I question are the following:

1. That since aggression is an instinct, it is bound to 'come out' in some direct form, and that it is more desirable to let it out than to keep it bottled up. Such a view seems not to take into account the many possibilities for diversion, modification, transformation, etc., which a drive can undergo and which form alternatives to keeping in and letting out.

2. That if a child is timid, inhibited or fearful it will be good for him to become openly aggressive. This assumption disregards the fact that a timid, inhibited or fearful child may well have become so at least partly because he is afraid of being punished if he is aggressive or because he feels guilty about it (depending on the stage of his superego development, i.e. on the extent of autonomous

functioning). Unless the child's guilt or anxiety about his own aggression is modified, the expression of it will increase, not reduce, his disturbance.

3. That if a child is unduly aggressive, verbalizing the meaning of his aggression will reduce the behaviour. This assumption is very respectably and properly derived from the classical analytic theory that symptoms are based on conflict, and that interpretation of the conflict resolves it and removes the symptoms. In structural terms we would say that clarification and interpretation of conflict put the ego in possession of new information which enables it to reassess the psychic situation which has given rise to conflict and then to alter its reaction to this situation. But such reassessment and readaptation can be brought about by interpretation only if the ego is in a fit state to alter its reaction, and if the interpretation was correct in the first place.

To arrive at the correct interpretation, the child's feelings must first be understood. It is tempting to assume that because a child is behaving in an aggressive way in so far as his behaviour is liable to harm someone or damage something, his accompanying feelings must necessarily be of a primarily angry or hostile nature. This may, however, be far from the truth; and we must find out how he is really feeling before we can decide how best to deal with his aggressive behaviour.

We must also know what the child's ego is capable of doing to modify his behaviour. Even a correct interpretation may be of no help to a child whose ego is unable to reassess the situation and alter its reaction. Some form of support to strengthen the ego may then also be a necessity.

It is relevant also to mention here the genetic fallacy: a child may have developed, in reaction to earlier conflict situations, a

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habitual mode of aggressive reaction. This reaction may then be used to deal with many later conflicts, and anxieties. Understanding and interpretation of the *original* conflict is not what is required to enable the child to deal with the *current* problem. In other words, the aggression, however clearly genetically linked with past conflicts, has to be first dealt with simply as a reaction to the current, and possibly quite different, situation.

Some clarification of these problems can be obtained if we make use of Freud's structural theory in relation to the psychoanalytic theory of instincts. (See C. Yorke's paper, p. 367.) By distinguishing between those behavioural manifestations which are a direct or derivative form of drive expression and those which are primarily expressions of ego-activity, we can begin to distinguish between examples of aggressive behaviour which are primarily an expression of hostile or angry wishes, impulses and fantasies, and those which are *reactions* to internal or external situations which in some way frustrate the child, or make him feel anxious, unhappy, distressed, etc.

In normal development we expect that at quite a young age, even at about two or three, children can begin to give up direct expressions of aggression such as hitting, kicking, biting and throwing, to divert their aggression into other channels such as speech, play, games and legitimate forms of competition and ultimately into sublimated forms of functioning which are distanced from the original drive expressions. These transformations are not solely dependent upon changes in the nature of the aggressive energy involved.* Changes in the form taken by aggress-

sion are also dependent to an important extent upon the child's structural development and the balance between the structures. It is a function of the ego to defend against aggressive drives on the one hand, and on the other to facilitate the channelling of energy into less dangerous activities. Some forms of aggressive behaviour which transcend normal limits are the result of maladapted defences on the part of the ego, e.g. anticipatory turning passive into active, and identification with the aggressor; others are attributable to failures of ego functioning due to constitutional defect, retardation due to environmental factors, or other kinds of distortion or malfunctioning which prevent the child from establishing normal defences against aggression and making normal adaptive use of aggression; yet others are due to identification with abnormally aggressive objects: identifying with one's parents is a normal function of the ego, but if the parents happen to be disturbed, the result of this normal process may be an abnormal identification resulting in abnormal behaviour.

In addition, children who have malfunctioning egos are likely to be in many respects more vulnerable to external and internal pressures, less capable of adapting and coping with new or difficult situations. Such children are more liable to experience extreme degrees of anxiety, fear, lack of safety, loss of well-being, drops in self-esteem, etc. In such children aggressive behaviour is very often then a reaction of fright, psychic pain, frustration, etc.

In normal development the superego gradually comes to provide the child with inner standards of behaviour as well as inner sources of praise and blame for achieving these standards or failing to do so. An inadequately developed superego can be one reason for poorly controlled aggression, an unduly severe superego can be one reason for timidity and inhibition of aggression. More complicated psychic situations can also occur in which, for various reasons, the superego comes to play an abnormal role in the control of aggression.

* Many questions may be raised concerning aggressive energy and its transformation via such processes as fusion with libido, neutralization and sublimation; further questions relate to how many forms of psychic energy there are, and whether or not all energy is derived from instinctual sources. These are complex problems, however, which require lengthy discussion in their own right, and cannot be pursued here.

The healthy development of object relationships is also an important factor and one which interacts very closely and intricately with structural development.

I would like, now, to illustrate some of these points. My first example is of a child whose aggressive behaviour arises not from conflict, nor from any constitutional ego defect; it is simply the result of a developmental structural imbalance due to deficiencies in handling and opportunities provided by the environment. Keith was the fourth of six children in a warm and loving but disorganized lower working-class family. They lived in overcrowded slum conditions with no space to play, no peace and quiet for talking, thinking, or asking questions, no possibility for pursuing any activity without interruption. The well-meaning but rather inadequate, inarticulate and ill-educated parents were not equipped to stimulate or even support ego development in their children, and had even given up the struggle to keep home and family clean and orderly.

Keith was a sturdy, tough little boy, of average intelligence. When he began attending the nursery school at the Hampstead Clinic at the age of four he soon established himself as a child who had to be watched by the teachers. He charged around like a bull in a china shop, disrupting games and activities rather than joining in. He would grab whatever toy or play materials took his fancy, and dealt with resistance from other children by bashing them. Keith's more spectacular achievements included pushing one child through a window and splitting another's head open by hurling a brick at him. Opposition from the teachers to any of Keith's wishes, or restrictions on his behaviour, resulted in violent and noisy tantrums. His speech was retarded and often incomprehensible. He was not malicious, however, and was genuinely sorry when he realized he had hurt or upset someone.

Keith's aggressive behaviour was the result of *insufficient* conflict and *insufficient* defence against drives. It was the result of ego and superego development lagging behind drive

development because of inadequate stimulation and support from the family for the development of ego-functions, and the parents' failure to provide appropriate models for normal identification in establishing superego standards. Keith therefore needed not interpretation, but the kind of consistent and firm but sympathetic handling that a good teacher can provide: examples in their own behaviour and attitudes for Keith to identify with; appropriate praise and reward or disapproval and punishment to help him learn standards of behaviour and make them part of his own superego; stimulation to try out new activities and interests into which energy could be channelled and discharged in less dangerous ways, and the necessary peace and quiet so that Keith could pursue such developing interests without interruptions; and help in the development of speech as an alternative to action for communicating needs, wishes, likes and dislikes, questions and reactions.

Superficially similar behaviour in another four-year-old boy proved to be of a quite different order. Robert, too, had a disruptive effect on the nursery school, interrupting activities, attacking other children or disturbing their games, and battling with the teachers. But whereas Keith was also a friendly, outgoing child, basically prepared to trust adults and gaining much pleasure from achieving their interest and approval, Robert was tense, fearful and suspicious, so that he could not develop the kind of emotional attachment to the nursery school teachers which had enabled them to influence Keith and alter his behaviour.

Robert provides an example of the role of identification and of the maladaptive development of defences in the production of aggressive behaviour. He was a child whose ego had to cope with a dangerous reality as well as instinctual dangers. He lived alone with his divorced mother who seemed near-psychotic and aggressive; her voice was always loud and rasping; her demands on Robert for perpetually good behaviour were geared to her own needs and wishes, taking little account of a

small child's needs or capacities. She could tolerate no sign of normal aggression or hostility in Robert. She considered Robert 'good' when he obeyed her instantly and completely, 'bad' when he did not. He was in some respects over-protected and smothered, but at the same time disobedience or just being a nuisance could provoke his mother into losing her temper and hitting him, sometimes violently enough to cause injury requiring hospital care. She also threatened to send him away. This mother had no conscious awareness of her hostility to Robert; she constantly emphasized her devoted and self-sacrificing affection for him, reproaching him for ingratitude and bad behaviour.

Robert was thus faced with a confusing, inconsistent and often frightening mother whose behaviour gave rise to appropriate realistic anxiety. Through the normal processes of identification he had taken over some of his mother's aggressive traits, and in addition had dealt with anxiety aroused by threats and attacks from mother via the defence mechanism of identification with the aggressor. In an attempt to maintain a loving relationship to his mother he displaced fears of attack from mother to other people who were then perceived as dangerous and were defensively attacked. He also used the defence mechanism of turning passive into active by provocation to deal with the anxiety aroused by mother's threats to send him away if he was 'bad', i.e. some of his aggressive behaviour was an attempt to provoke the rejection which he feared, and at the same time to seek reassurance that it would *not* happen.

Instinctual anxiety was also greater than normal, being enhanced by mother's contradictory behaviour and attitudes. Some aggression was projected to defend against the guilt it aroused, a mechanism which increased his fear of external objects. The mother perceived Robert as if he were dangerously aggressive, a view of himself which he was beginning to take over from her. All this added to his difficulty in finding an appropriate compromise between expression and inhibition of instincts.

Finally, Robert had a very severe, punitive superego, partly based on internalization of his mother's punitive attitudes, but reinforced by his own aggression turned back on himself via the superego.

He was caught in a vicious circle in which, through normal processes of identification, and various defensive processes, he had developed habitual forms of aggressive reactions, which, however, aroused the condemnation of his own superego as well as his mother's anger. His own aggressive behaviour then made him more anxious, so that he was helped by measures from the teacher which discouraged it and directed it into more acceptable channels. But in Robert's case, unlike Keith, educational techniques were not enough to cope with his internalized conflicts and continuing conflicts with a confusing external world. He required psychotherapy as well, but verbalizing and interpreting aggressive wishes and impulses would not have been appropriate, at least in the initial stages of treatment. Simply making him more aware of the aggressive element in his behaviour would merely have increased his anxiety, resulting in more defensive aggression, and continuing the vicious circle. Further, at this stage verbalization of aggressive instinctual impulses and wishes would have colluded with the mother's tendency to view Robert and to make him see himself as the 'bad', aggressive one, herself the 'good' one of the family.

What first had to be understood and verbalized was, on the one hand, Robert's *fear* of his mother, and, through displacement, of other people; and on the other hand his *fear* of his own aggression, which he expected to result in rejection and/or retaliation. In addition, he had to be helped to distinguish between the *real* dangers in the external world and his own exaggerations of these dangers from his various defence mechanisms.

The role sometimes played by the superego in producing aggressive behaviour is illustrated by John, a 14-year-old referred for a dramatic worsening in his school work: with an IQ of over 150 he had suddenly plummeted from

top to bottom of his grammar school class and was about to be removed from the A-stream. Treatment indicated that this deterioration was linked with a traumatic experience the previous year when he had to be circumcised following a tightening of his foreskin resulting in much pain. John had already been strongly defended against aggression, and was always good, polite, well-behaved and obedient towards his very strict and rigid parents. He experienced the circumcision as a confirmation of the dangers of any kind of aggressive or competitive impulse or wish, and his inhibition of aggression spread to all kinds of active behaviour, including school work.

John had taken over his parents' condemnation of aggressive behaviour, adding his own strictures to theirs, producing a very severe, punitive superego. When he began treatment he was afraid even to talk to the therapist for fear of saying something bad. Gradually he began to show her some of his interests and preoccupations in non-verbal ways. Indicating his conflicts in action involved actual aggressive behaviour, lighting fires, knocking furniture about, throwing water 'bombs' and so on. But the boy's overriding concern was with the guilt and anxiety aroused by the wishes and impulses underlying this behaviour. He was trying to ascertain whether the therapist could accept and help him contain these feelings; and it was this search for reassurance, and help in controlling feelings and impulses, his doubt whether he could feel 'safe', which had to be understood before the content of the aggression could be taken up. It was certainly not 'good for' John to express his aggression until he could do so in ways that did not arouse anxiety and guilt, and lengthy treatment was required before this stage was reached.

Finally, I would like to mention eight-year-old Paul, whose difficulties resembled those of Robert in many ways. Paul, too, had developed the same kind of maladaptive defences (identification with the aggressor, displacement, projection, turning passive into active by provocation, etc.); the normal processes of identification contributed, in this

case, to the reproduction of his father's aggressive, sadistic and denigrating behaviour toward his mother; in particular, Paul tried to use his father's tactics of bullying people into submission whenever they disappointed him in some way. This, combined with his tendency to test to the limits the object's tolerance for his aggression, for which he also feared rejection, led to some extreme aggressive outbursts, which could only be contained through understanding the deep despair, and sudden catastrophic drop in self-esteem and loss of feelings of safety occasioned by the object's withdrawal of interest, or failure to meet his needs. For example, Paul began one session early in treatment hurling furniture about, attacking the therapist, destroying his toys. He could not listen to the therapist, nor could he indicate what his behaviour might be to do with. It certainly was not a straightforward 'letting out' of the aggressive instinct, and clearly afforded him no relief or satisfaction, since the longer it went on, the more desperate he became. Only when it was nearly time to leave did he reveal the cause of his outburst – his mother had said she might be late fetching him after his session. What could then be understood was his immediate exaggeration of this into a fear that she would not come at all, but would abandon him, so that he would starve, and have no home. He felt utterly lost, unwanted and worthless. His aggressive outburst, displaced on to the therapist, was an attempt to prove to himself that he was still wanted, however 'bad' he was, and simultaneously to bully therapist/mother into staying with him.

I hope that these cases have served to illustrate the complexity of the considerations involved in deciding how best to handle aggressive behaviour – or the lack of it – in a child. There are many courses open to us in addition to encouraging the child to express aggression or inhibit it.

Keith illustrated the non-interpretative, educational measures needed to help a child whose aggressive behaviour was not the result of conflict, or disturbance in drive develop-

ment, but of developmental failure on the side of the ego and superego, which rendered the ego incapable of performing its functions of defending against aggressive wishes and impulses, and channelling the energy into other activities and behaviour less closely tied to instinctual functioning. In Robert's case we saw an ego not retarded in development, but still unable to modify its handling of instinctual pressures and external dangers. This ego was handicapped by distorted perceptions of the external world as well as of the self, and trapped in a vicious circle perpetuated by the use of maladaptive defences and by identification with an abnormal mother. We saw, too, that the feelings which first had to be understood in Robert's case were not primarily hostile or angry ones, but *fear* and *anxiety*. Paul was somewhat similar to Robert, but in addition demonstrated how a sudden loss of

feelings of safety and self-esteem can contribute to aggressive behaviour of a defensive kind. In John's case we saw the role played by the superego, and the necessity for helping the boy find ways of channelling his aggression which did not arouse anxiety and guilt.

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Coping with reality: the child's defences against the external world*

BY ANNE HURRY† AND JOSEPH SANDLER‡

Psychoanalysis has traditionally been viewed as dealing with internal and internalized conflicts rather than with current conflicts with the external world. This is partly because the initial public impact of psychoanalysis occurred during the second phase of its development (1897–1923) at a time when Freud had turned away from the traumatogenic theory of neurosis and was mainly concerned with the way in which unconscious instinctual drives and wishes expressed themselves in the clinical psychoanalytic situation with adult patients. The main emphasis at this time was on the way in which such drives were themselves in conflict with one another, as well as on the role of the childhood internalizations of external reality, and the past and present conflicts to which these internalizations contributed.

Yet from the inception of the structural theory in 'The Ego and the Id' (1923), and its further development in 'Inhibitions, Symptoms and Anxiety' (1926), Freud saw the ego as a central regulating agency, mediating between the demands of the id, the superego and external reality, and defences were seen as being set in motion by an anxiety signal which could arise from any of these sources. The ego was regarded as being the servant of three masters, its main task being to find ways of reconciling the various demands imposed upon it from the three different sources.

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Of recent years this 'servant' has been recognized as possessing a considerable freedom of action of its own, and defences have come to be seen as particular instances of more general modes of adaptation. Hartmann's work on the 'conflict-free' sphere of the ego and on the concepts of 'primary' and 'secondary' autonomy (1939) have given us a view of man who is no longer always driven completely by his instinctual drives, or having to follow the demands of his ideals and conscience on the one hand or of the external world on the other. Rapaport introduced the concepts of the ego's autonomy from the environment and from the drives, and more recently Sandler (1960*a*) has spoken of the ego's autonomy in relation to the superego – one may hear the 'voice of conscience' but need not blindly obey it.

In so far as we can speak of a general aim for psychoanalytic treatment we can regard it as that of increasing the autonomy of the individual in these three respects, of widening the sphere in which the individual feels safe and has a free choice of action (Sandler, 1960*a*).

In the case of the young child the immediate interaction of the child with the external world is of great importance. In 1936 Anna Freud drew particular attention to the child's defences against the pain arising from sources in the outside world. She commented:

The greater the importance of the outside world as a source of pleasure and interest, the more opportunity is there to experience 'pain' from that quarter... During this period the individual is still too weak to oppose the outside world actively, to defend himself against it by means of physical force or to modify it in accordance with his own will; as a rule the child is too helpless physically to take to flight and his understanding is as yet too limited for him to see the inevitable in the light of reason and submit to it. In this period of immaturity and dependence the ego, besides

making efforts to master instinctual stimuli, endeavours in all kinds of ways to defend itself against the objective 'pain' and dangers which menace it.

The small child is in no position to fight, to fly from or to change his environment. Child analysts do not generally aim towards bringing about current autonomy from the environment for the child patient, but rather to restore him to the path of 'normal' development within this given environment, a development which carries the hope of eventual adult autonomy.

In the 'average expectable environment' (Hartmann, 1939) there are a number of adaptive age-appropriate manoeuvres to which the child may resort in order to make his situation of dependence and helplessness more tolerable. In particular, turning to fantasy as well as play involving some form of role-reversal appear to enable him to bear his dependent and relatively helpless situation more easily and to prepare him for his later adult role. As ego development proceeds, and as further skills are acquired, such defensive fantasies and activities form the basis for an ever-increasing range of ego capacities and 'normal' sublimations.

But such adaptive manoeuvres will not suffice for the child in an intolerable environmental situation, or for one forced to carry the burden of a severe family disturbance. It is characteristic of the defences adopted in such circumstances that they tend to hinder the way to further personality development rather than to foster it. They may enable the child to cope with one set of circumstances, but may equally make it impossible for him to cope with new and different ones. Forced to bend his character to cope with the reality, he must defend against his impulses in ways which are more extreme than usual. Thus there is less hope of future autonomy in relation either to the environment or to the drives. Further, with the internalization of immoderate reality-demands there will be less possibility of future autonomy from the superego. Unfortunately,

such ways of coping with reality have not yet been systematically studied, although we are beginning to know more about them. The child may, for instance, identify with threatening aspects of the outer world, may grossly obliterate facts, or misperceive and misinterpret them to a pathological degree.

Ordinarily the child builds up his representational world (Sandler, 1962) – his inner world, including his perceptual world – partly on the basis of his own observations, partly on the basis of what is presented to him by others (and particularly by his parents), and partly on the basis of his own fantasy. But if these sets of information are contradictory he may attempt to resolve the contradictions by denying the evidence of his own eyes. Or, if information from any one of these areas produces too great a degree of pain it may be suppressed and the child may rely more heavily on information from other areas. Thus we all know the child who retreats to reality when fantasy is too frightening. But a child may also explain a reality event or situation on the basis of fantasy because the reality is too painful or too threatening.

The child undertakes such defensive manoeuvres in an attempt to maintain an inner feeling of safety (Sandler, 1960*b*) even though this may be short-lived. He may also tend to rely on his own fantasy constructions because the factual explanation is not available to him. Here we must consider developmental factors – particularly whether the child's understanding has reached the stage where he can 'see the inevitable in the light of reason'.

Here we can only discuss aspects of two cases of children placed in intolerable reality situations, who had both reacted in ways which hindered the possibility of progressive development. We hope to show that through analysis of their means of coping with their current and past environments it was possible not only to open the way to future development, but also to help them to achieve a relative autonomy even within their pathogenic environments.

Case 1

Peter came into analysis at three years because of depression, withdrawal and infantile speech. He would sit huddled in a corner of the nursery school for most of the day. His mother was a seriously depressed woman who had made several suicide attempts, each time spending periods in mental hospitals. When not in hospital she was often extremely withdrawn, lying on the sitting-room floor, not speaking to anyone. At other times, she would resort to frantic activity, rearranging all the furniture, with both the radio and television turned on at full blast. She had herself had a very deprived childhood, and she had little to offer her own children. In so far as they impinged upon her, or made demands, she resented and even hated them. She would shout at Peter 'You make me ill, you make me want to go to hospital!' Or, 'Don't call me Mummy, I hate that word.' In the course of his analysis Peter emerged as a child terrified of his mother and terrified at the thought of losing her. But this discovery took a long time because initially he strenuously denied both his fears and the fact of his mother's illness. His relationship to his mother came to be repeated in the transference: he was both terrified of the therapist (A.H.) and of losing her. At the end of sessions he would reassure her and himself, and would also reassure the furniture by saying, 'Goodbye table, see you tomorrow. Goodbye chair, see you tomorrow.' On Fridays he found it almost impossible to leave. In sessions the therapist had to play at being very ill while Peter played doctor; he would shake his head, saying, 'I don't know what's the trouble with you.' Yet of his mother he would say, 'She is never sick' or 'My Mummy has never been away.' He was unable to relinquish this denial until the first holiday break was nearly due. This he viewed in advance as being dropped and lost, broken and starved. He wanted to be close to the therapist, to be fed and to be looked after, but he still kept his sadness at bay and refused to discuss the holidays. One day, however, he sat on the floor chanting

repeatedly and mechanically, 'Don't cry, don't cry, don't cry.' When the therapist suggested that this was something people had once said to him, he said, 'Yes, they did, they really did.' From this point it was possible gradually to work through his reaction to his mother's many sudden disappearances.

Why had his denial been so extreme? On his return from holiday he showed this very clearly. With the toy animals he played the story of a baby lamb, dead in the snow because the mother sheep forgot it, left it alone and did not feed it. The lamb had been 'four' but 'still needed looking after'. To accept that his mother was as she in fact was meant that Peter had to face the intolerable terror of having no one to look after him, of being completely lost. By his denial he had attempted to preserve some inner safety, but he had been able to do so only in the context of the relative security provided by the analytic relationship. With the threatened loss of this relationship over the vacation he had to relinquish the denial and to face the dangers caused by his mother's unreliability.

A further reason for Peter's need to defend in this way was his extreme guilt. As the analysis of the transference explored the guilt over his anger, resentment and death wishes towards the therapist, who so frustrated and endangered him by leaving at the end of sessions and on holidays, it could be seen how he had taken the blame upon himself for his mother's disappearances and illness. Peter could experience the fact that his anger did not kill the therapist or make her ill. But the fact of his mother's condition remained a puzzling mystery to him. With no explanations Peter was left helpless and powerless to face the vagaries of chance. He still could explain these mysteries only in terms of the explanation his mother had given him, i.e. 'you make me want to go to hospital', which reinforced the fantasy that he was to blame. Moreover, to feel guilty but consequently powerful, in control, was safer for him than to feel helpless. Thus it was necessary both to

analyse his terror of helplessness, and also to give him the real explanation that his mother was ill. Although at four Peter could not understand the complexities of mental illness, he could well understand, in his own terms, that Mummy had worries as he had, that she was in need of help and that she did not choose her behaviour or her inability to love. He could also accept the fact that while she might wish to see him as the cause of her illness, she could also be wrong, and that he was in reality not so very dangerous and threatening to her.

It goes almost without saying that the giving of information of this kind requires careful timing. Given too early, or without the concomitant working through of guilt feelings, it may merely provide a magical defensive formula which cannot be integrated by the child. Given at the right time it may provide a stepping stone which can enable the child to move on.

In Peter's case reality was intolerable because of a relatively straightforward rejection on the part of the mother. The effects of this rejection, although extreme, were also relatively straightforward. But there are many other cases in which the child is used by the family in a more complex way, and where the effects of the family's use of, and view of the child may be extremely difficult to unravel. In recent years much has been written on the subject of neurotic interaction within the family. Frequently family therapy is regarded as an obvious method of dealing with current family interactions. But parents are often not prepared to attend for treatment although they may be prepared to send their child, especially if he presents overt and disturbing symptoms. It is sometimes thought that in accepting such a child for individual treatment, one reinforces family patterns of scapegoating by agreeing that the child is the ill member of the family. But to refuse treatment on this basis is unfounded, as we know that therapy can be effective, provided that the nature of the reality with which the child is faced and his methods of coping with it are

brought out into the open, and the family can tolerate the child's improvement. Further, individual treatment makes it possible to experience in the transference a repetition of those aspects of a 'crazy' reality which have been internalized in the past.

Case 2

Josie was referred to the Hampstead Clinic at 11 for a variety of difficulties. These included severe eating and sleeping problems, psychosomatic illness and school phobia. A close, clinging and demanding relationship to the mother figured most prominently. Josie had regressed from oedipal to pre-oedipal levels of object relationships largely under the impact of conflicts around death wishes towards her mother. Aggression at all levels was extremely guilt-provoking and desperately defended against. The early months of the analysis clarified Josie's view of herself as totally unlovable because she was so bad, so greedy, messy, angry, destructive and damaged.

It was to emerge that Josie was used by each parent in the service of his or her own needs, and that she was used by both parents as the scapegoat and the battleground on which their conflicts were fought out.

The most pathogenic factor in her environment was the nature of her mother's relationship to her. Mrs G. had never been able to tolerate her own aggression. From childhood, projection had played a major part in her battery of defences. Repressing and obliterating her own wishes to attack, she then feared all others as attackers. She made use of projection in relation to Josie even before the birth, being consciously afraid that the unborn baby was killing her. She continued to use projection in this manner throughout Josie's development, being prey to the constant fear that Josie only hated her and wanted to kill her. Thus she constantly revived, intensified and drew *the child's* own aggressive wishes into consciousness. The normal developmental evolution of drive expression from direct and primitive to more distanced and less

conflictual forms was grossly interfered with. The development of relative autonomy and of progressively adaptive defences was impeded, and Josie was left with no alternative but to accept those defences forced upon her by her mother.

The mother denied her anger, displaced her hate on to other objects and reactively stressed her love. And Josie did too. She and her mother spent much of their time in mutual assurances of love, in exchanging placatory gifts and in denying their aggression. Frequently they would discuss their shared dislike for an object on to whom they had mutually displaced their hostility.

Soon after the start of treatment one could see how ineffective and brittle this shared defence system was. Primitive aggressive irruptions began to occur on both sides, on each occasion followed by an intensification of the usual defences. As a consequence, treatment itself became extremely threatening. It proved impossible to analyse Josie's defences *in vacuo*: but it was possible to analyse the defences of both mother and daughter in Josie's analysis. The turning point came when Mrs G. crashed the family car with her youngest child in it. No one was seriously injured, and her first reaction was to go out and buy Josie a present. Josie came to her session bringing the mother's present to show her therapist (A.H.), blaming someone else for the accident. She spent her time making paper flowers as a present for her mother. The crepe paper she used had to be held under water to 'take out the dye'. Josie was quite blank when the therapist tried to take up the significance of Josie's own present. But she was greatly relieved when the therapist spoke of the function of her mother's present in terms of the mother's attempt to say, 'I am a safe, loving, giving mother and not a crashing, killing mother.' Having seen this Josie could begin to accept the function of her own present, and to see what lay behind her own need to propitiate. It became clear that the shared defensive system had served to protect each member of the family, not only from the awareness of

their own aggression, but also from the awareness of the aggression of the others. So far as Josie was concerned, it could be seen how her fear of her own death wishes and of mother's was due not only to their fantasied omnipotence, but also to Josie's acceptance of her mother's view of the omnipotence of aggression. Once this was in the open it was possible for Josie to begin to counterbalance it with her rational awareness that wishes did not kill people.

Father's relationship to Josie in no way compensated for the effects of Mother's. Wanting a son rather than a daughter, he constantly made clear to Josie that he viewed her as a damaged, messy, useless creature. When he came to analyse Josie's view of her femininity it was necessary to clarify not only her own guilt and self-denigration, but also the internalization of the father's view of women and thus of herself.

Finally, Josie's self-denigration was compounded, and confirmed by the way both parents used her as the family scapegoat. Father and mother were from widely different cultures. Mrs G. came from a rigid upper-class Protestant background, from which she had broken away to become an artist. Consciously she believed in freedom and self-expression, but in her handling of Josie her condemnation of instinctual urges was constantly apparent. Mr G. was from a Jewish refugee family. He went to an English public school and, like his wife, rejected his family mores. He believed in strict training and condemned the 'emotional' Jewishness of his childhood. But in his case as well, the rejection of childhood standards was no more than skin deep.

In all areas of behaviour and thought Josie had encountered and had internalized conflicting standards, and for a long time it was necessary to work on the clash between her 'Mummy conscience' and her 'Daddy conscience' which lay at the root of her view that everything she did, thought, or felt was wrong. It was as she allowed herself to become aware of the conflicting attitudes around and within

her that Josie could begin to develop her own, more appropriate, standards.*

Josie, in her role of the disturbed child, contributed to the maintenance of the family equilibrium. By their highly inconsistent handling the parents maintained her in this role, condemning but subtly rewarding her symptoms. It is worth noting that although Josie had been severely disturbed since the age of two, it was not until she was nearly 11 that the parents accepted the Clinic's offer of treatment. They did not do so, in fact, until Josie's malfunctioning became socially overt. The value of her symptoms to the family, and their reinforcement of them, could clearly be seen in their handling of her sleeping disturbance. Both parents took sleeping pills, and Josie would frequently be dosed with them. In addition, her bed was put in the parents' room, thus enabling them to deny their own sexual difficulties and to place the blame on Josie.

At the start of treatment both parents insisted 'we have a very happy marriage'. It was as Josie began to change and to lose her symptoms that it could be seen how far the marriage and the parental idealization of it had been maintained at Josie's expense. Quarrels became frequent and violent. Within the same interview the mother would describe Josie as 'perfectly awful' while describing her husband as loving and understanding; this alternated with her saying that Josie was 'fine', while her husband was 'a beast and a bully'. The father followed a similar pattern. On the one occasion when things appeared to be going well between him and Josie, Mrs G. rang the therapist to say, 'I'm so afraid, something dreadful must be brewing up in Josie.'

The increase in parental quarrels which followed the changes which were beginning in Josie, further stimulated her guilt. Many of the quarrels were directly about her, beginning with clashes over what she should be like, or

how she should be treated. But she was expected to deny these rows, as did her parents. Josie would witness screaming fights, with the parents struggling on the floor. Mother would then tell her they had not 'really' been quarrelling. In treatment, after such scenes, Josie would withdraw miserably into her homework, later emerging from this to make desperate efforts to be a 'good' patient. Before we could reach the oedipal roots of her guilt, it was necessary not only to take up the transference aspects of this but also to clarify and to contradict the parents' view of her. The therapist could discuss with Josie her mother's use of denial, her need to preserve the image of an ideal happy marriage and her consequent externalization of blame on to Josie.

We have commented earlier on the building up of the representational world on the basis of information from three spheres: direct observation, information presented by others, and fantasy. In Josie's case we can see clearly how observational information was distorted and her fantasied guilt and self-denigration were constantly reinforced by the view of herself and of themselves presented by each parent separately, and by both parents acting in concert; all of this both currently and in the past. While her analysis was often difficult and painful, it was eventually possible for her to view both herself and her parents more realistically and to refuse to accept the blame which they continued to try to place on her shoulders. In other words, it became possible for her at this age to achieve some degree of autonomy from the demands of her pathogenic environment, while continuing to live in it. It seems unlikely that such a result could have been achieved without the clarification of her parents' conflicts and defences, and the analysis of her response to these.

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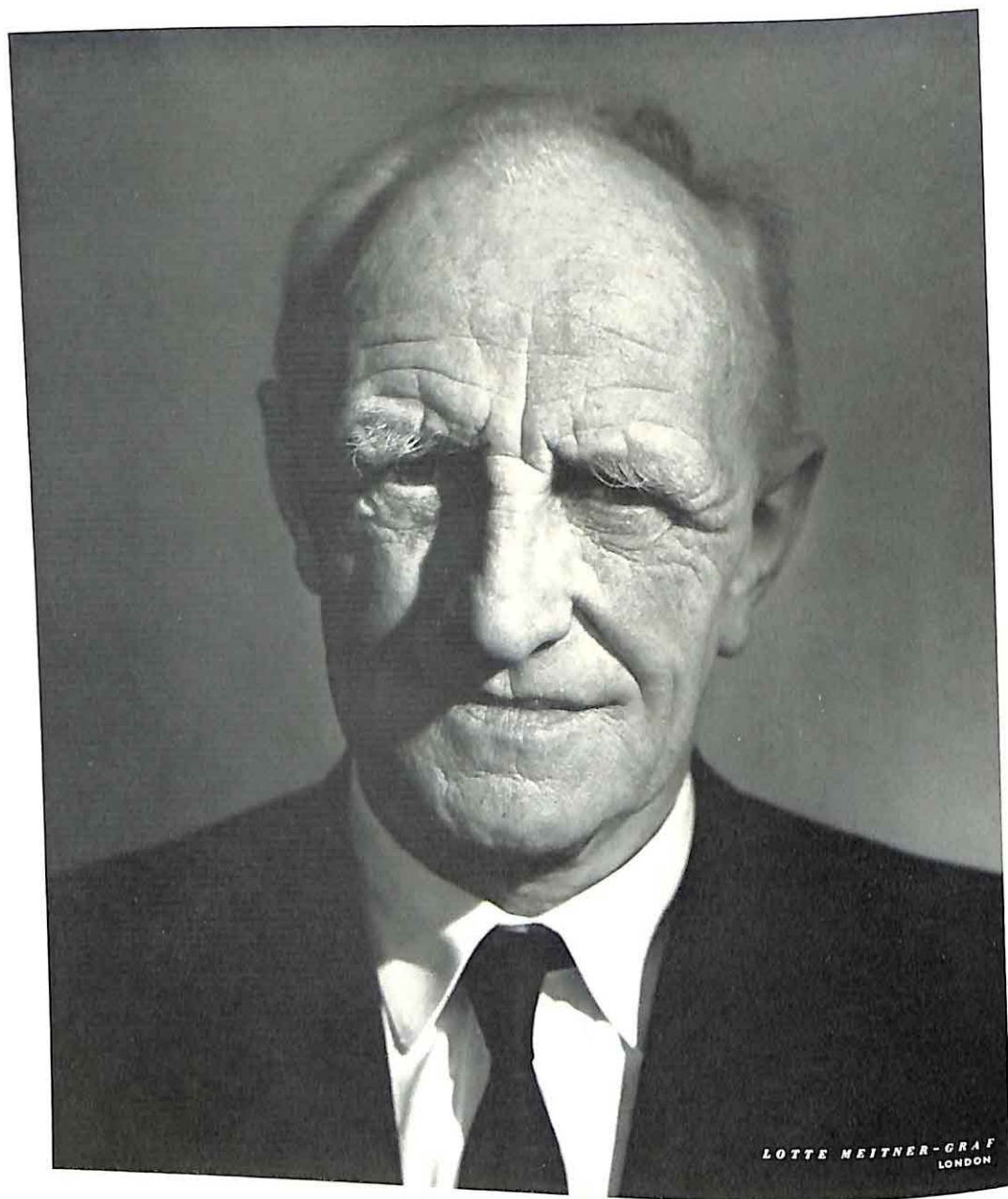
* It is of interest that Vogel & Bell (1960) have shown how the scapegoating of one child typically occurs in families where there are conflicting value orientations.

Foundation, Inc., New York; the Foundation for Research in Psychoanalysis, Beverly Hills, California; the Freud Centenary Fund, London; the Anna Freud Foundation, New York; the Grant

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Photograph: Lotte Meitner-Graf
DONALD W. WINNICOTT, M.A., F.R.C.P., M.R.C.S., F.B.Ps.S.

Obituary

D. W. WINNICOTT

Dr Winnicott died suddenly at the age of 72 in his home on 25 January 1971. Just a week earlier, he had corrected the galleys of his books, *Therapeutic Consultations in Child Psychiatry* and *Playing and Reality*, and was busy working on his contribution to a symposium on Aggression for the Vienna Psychoanalytic Congress in July 1971. He was awake in his sensibility and creative of mind right to the very end.

Winnicott's had been a long, sustained and very dynamic life. He had known acclaim and success as well as personal sorrows and privations. He had come to psychoanalysis from paediatrics in the early 1930s, and had been analysed by James Strachey and Joan Riviere. In the 1930s, he came deeply under the influence of Melanie Klein's work, and he considered it always as the most creative influence in his professional life, after Freud's work.

Winnicott was adamantly an individual and stayed peculiarly himself throughout his life. He was a man of great modesty on the one hand, and had true belief in his own vision on the other. What he brought to psychoanalysis essentially was a humane empiricism. His intensive work as a paediatrician with infants and mothers stamped the whole style of his theory making, as well as clinical approach. Winnicott also combined the very happy and fortunate gifts of revolutionary clinical work and the ability to abstract from it simple and profound concepts. His first statement of his work with children was in his classical paper, 'Observations of Infants in a Set Situation' in 1941. It was his capacity to observe the extremely simple detail and evolve from it most far-reaching theoretical constructs that characterized his particular form of sensibility. It was his observation of the infant's rhythm of

playing with the spatula that some ten years later, in 1951, led to his postulation of the by now internationally famous and current concept of the 'transitional object and transitional phenomena'.

In his Chairman's address to the Medical Section of the British Psychological Society in 1948, entitled 'Paediatrics and Psychiatry', Winnicott gave his first definitive statement of his credo, namely 'The importance of the individual's contact with shared reality and the development of this from the start of the infant's life'. At a time when psychoanalytic theoreticians, particularly of the Kleinian orientation, had maximized the emphasis on the purely internal aspects of conflict, Winnicott made his by now famous statement: 'There is no such thing as a baby.' And as he himself said: 'I was alarmed to hear myself utter these words, and tried to justify myself by pointing out that if you show me a baby you also show me someone caring for the baby, or at least a pram with someone's eyes and ears glued to it.'

Winnicott was one of the very few analysts who had throughout his practice stayed in touch with children, got involved in the therapeutic care and treatment of severely regressed and sick adult patients, as well as providing consultative facilitation to individuals in health who were just getting stuck at some critical and crucial moment of their own growth. It was from this rich and complex matrix of clinical experience that Winnicott evolved all his theories of management of the regressed moment in the patient, the holding function of the transference, and the shift from the emphasis on conflict to paradox in psychic experience.

All this did not make it easy going for him with his colleagues. For example, he was

deeply disappointed that the British Psycho-Analytical Society never used him to teach child-analysis, something about which he knew more than anyone else. But gradually his work won itself the serious study and acclaim that it deserved. The forum of the Medical Section of the British Psychological Society played a very important role in his being able to put his point of view in front of audiences larger than merely a psychoanalytic group. Winnicott was not a factional man, and believed almost fanatically that wisdom and insight into human beings could never become the monopoly of any one organized group.

Winnicott also had a very distinguished career of professional honours. He was a Fellow of the Royal College of Physicians; twice President of the British Psycho-Analytical Society; Chairman of the Medical Section of the British Psychological Society; President of

the Paediatric Section of the Royal Society of Medicine; and was the James Spence medallist for 1968, an honour that gave him particularly great personal satisfaction. He had lectured widely to all sorts of groups and associations all over the world, and his capacity to put his own work across with almost a childlike enthusiasm and playfulness, and without any rigidity of dogma, made him a very popular and much-loved speaker.

Only a very few lives ripen to a climax where fruition and death coincide. Winnicott's was one such. All those he had nurtured by his presence, and thousands more who knew him and will know him from his writings alone, will remember him with a tenderness and gratitude as the maverick sage of psychoanalysis and paediatrics.

M. MASUD R. KHAN

Book Reviews

Five Questions in Search of an Answer. By

DAVID STAFFORD-CLARK. London: Nelson.

1970. Pp. xii + 184. £2.25.

Gaze aversion is symptomatic of autism; it also characterizes the behaviour of many Christians when they are confronted with the problem of suffering. In the past Christian theology offered some model for coming to terms with the problem. Now, in a secular age, with any religious frame of reference largely diminished as the god of the gaps becomes smaller, it is not surprising that the Christian's defence against overwhelming anxiety is to ignore the problem.

Dr Stafford-Clark, however, attempts to grapple with its horns, resulting in a book which reads like a stream of consciousness, an echoing *cri de coeur*, a cathartic release. As a Modern Man in Search of a Soul he relates his own personal quest to find ultimate meaning behind the confrontation between the assumptions of Christianity and the living reality of the human condition. The book is subtitled 'Religion and Life: Some Inescapable Contradictions'.

The five questions he asks have a kaleidoscopic quality. The chapter headings are thus: (1) The Nature of the Problem: Whatever Happened to the Love of God? (2) The Need to Believe: But How, in What? (3) Who is Jesus Christ, and Why is He? (4) If there be No God, How then can I be a Captain? (5) Who's to Doom, When the Judge Himself is Dragged to the Bar? The publisher's synopsis lists the questions as: Where does the division between mind and body fall, or are they equally mortal? If God is dead, can life retain any meaning; and if he lives, what is his responsibility for the fact of evil? How can we reconcile Christ's divinity with his human nature? Should we see the resurrection as a physical or a mythical truth?

The basic questions tend to expand and contract. In their articulated verbal form they appear distorted, like a series of bizarre and shimmering reflexions in a hall of mirrors. Words are but poor vehicles to convey the agony of the spirit.

Yet however the questions are phrased they have a common core, which in degrees has a meaning common to all men. Though what may be the

author's particular preoccupation may not be the reader's and certain aspects of the problem may be neglected or omitted as personal concern dictates. For instance, Dr Stafford-Clark has little to say about the problem of prayer: 'Whether our expectations include eternal life, or simply more satisfaction, or relief in this one, whether we work, pray, or look to sex, drugs or violence for a release from despair, we are driven alike by some silent merciless necessity.'

He devotes appendices to sex, drugs and violence. But what of prayer? Does God answer prayer? Are Christians deluded in believing a 'heads I win, tails you lose' type of argument? Is God really active in the world? If so, what is the evidence of God's activity? What sort of evidence should we look for?

It seems strange that in this respect Dr Stafford-Clark, as a psychiatrist, has so little to say about the relationship between mental illness and religion. Persons claiming to have direct contact with God are, in our day, often treated as being mentally ill, at least by the psychiatrist if not by the priest: 'The opposite error to the application of unconscious primitive standards to conscious and complicated problems, is the attempt to apply the critical standards of everyday conscious life to the products of unconscious mental activity: this happens when patients with obsessional illnesses are led by over-zealous but misguided priests into extreme scruples or interminably obsessional confessions: or when visions and ecstasies which are in fact symptoms of intoxication or developing mental illness are accepted as supernatural manifestations.'

But can we be so sure that these are always only symptoms of 'developing mental illness'? And if they are, what of their meaning to 'the patient'? Kenneth Dewhurst and A. W. Beard, writing on 'Sudden Religious Conversions in Temporal Lobe Epilepsy' (*Br. J. Psychiat.* 1970, 117, 497-507), state: 'In their study of the schizophrenia-line psychoses of epilepsy, Slater and Beard found that mystical delusional experiences were "remarkably common". Patients were convinced of the reality and validity of their religious experiences.' George Rosen in his book *Madness in Society* and his

'Comparative Historical Review of Emotion and Sensibility in Ages of Anxiety' (*Am. J. Psychiat.* 1967, 124, 771-784) highlights the cultural determinants of madness. The prophet of one era may be the schizophrenic of the next. Not only may the 'voices' or the 'visions' be called into question but as Andrew C. Smith concludes, in his 'Notes on Difficulties in the Definition of Delusion' (*Br. J. med. Psychol.* 1968, 41, 255): 'Certainly some people are indisputably deluded, by all the criteria, but the borderline is defined by society, can shift, and can be unclear in the individual case.' He argues that no absolute distinction can be drawn between delusion and other forms of belief.

Thus, unfortunately, Dr Stafford-Clark's book ignores the problems peculiar to mental illness and religion. Perhaps for a sufferer from depression who has lost all faith in God, a sufferer from temporal lobe epilepsy who claims to have seen God, or a sufferer from schizophrenia who claims to be God, there is no answer.

Dr Stafford-Clark's solution to the general problem of suffering is predictable: 'I cling to the hope of love, the hope for all the world. That was the hope of Jesus, that is the hope of all religion. Truly for me, and I believe for all men, the hope of love is the only hope; the only foundation for belief. For me the hope of love is better than the certainty of justice.' Put like that, who can disagree? Yet it is the irony of the human condition that though the ideal may be one thing, its interpretation and execution may be very much another. For, after a disturbing description of tortures inflicted upon heretics and witches Dr Stafford-Clark concludes: 'It is necessary to remember that all this was done in the name of a loving God, and to save souls for a Christ who had already been tortured to death as man's redeemer.'

Perhaps the answer to Dr Stafford-Clark's five questions is to be found in the creative form of displacement activity Voltaire recommends at the end of *Candide*: that of going out and digging the garden.

P. R. PEARSON

The Sheppard and Enoch Pratt Hospital (1853-1970): A History. By BLISS FORBUSH. Philadelphia: Lippincott. 1971. Pp. 266. \$7.50.

This book is a historical account of one of the oldest private mental hospitals in the United States, written by Bliss Forbush, who has since

1957 been serving first as one of the members and then as the President of the Board of Trustees of the hospital. The book portrays a group of dedicated trustees working ably in collaboration with equally dedicated medical and paramedical staff under four very capable medical directors to achieve the distinguished status of the hospital in the history of American psychiatry as a centre for treatment, training and research. As Dr Forbush writes candidly and movingly about the progression and the regression during over 80 years life of the hospital and how and why did all these occur in perspective of time (e.g. depression, wars, changes in the psychiatric world, redistribution of urban-suburban population, etc.), his book becomes more than a history of a single hospital - even though whatever he touches upon must be skeleton. The book most impressively demonstrates, through numerous accounts of events, that the human being can be the master in the adaptation to his world and that in adaptation he has to be reality oriented and often forgo the complete fulfilment of an ideal.

Reflecting the mood of the Board of Trustees, Dr Forbush says proudly that they (the past and the present) have been successfully fulfilling the desire of Moses Sheppard, the founder of the hospital, which is 'I desire to invest the estate in such a way as to meet some need that would not otherwise be met and to see that the money could continue to be a blessing to men and women on down through the generations.' Apart from keeping the most beautiful grounds of all the mental hospitals, they have selected four medical directors who have most competently made the hospital in keeping with the psychiatric movement of the times. Dr Brush (1891-1920) worked towards overcoming the stigma of the utilization of the hospital as a place for recovery from mental illnesses and towards improving humane treatment of mentally ill. Dr Chapman (1920-48) and Dr Murdock (1949-65) towards making the hospital one of the psychiatric centres which offers superb care of the patient, qualified training of psychotherapists and time memorable research works. It was at this hospital Harry Stack Sullivan conducted his research on schizophrenia and reported 90+ % cure and it was at this hospital Lewis B. Hill, by example and precept, inspired many scores of young psychiatrists to become excellent psychotherapists for schizophrenics. Now, Dr Gibson (1965-), without sacrificing

what his predecessors have accomplished, moves towards extending services to the younger patients and the greater community beyond the walls of the hospital.

The book proclaims to be a history which, indeed, should be recorded and even summarized for future new members of the trustees, for the past and the present and the future friends of the hospital. This is not a book intended for the practising clinician, except for those who are interested in its psychiatric history. Dr Forbush did not make any effort to correlate the various developments in his hospital with the actual scene of American psychiatry, yet his faithful reporting of the documents, chiefly those submitted by the medical directors to the Board of Trustees, candidly offers additional documentations. For

instance, his history of diagnostic terminology as used at different times, his report on the introduction of electric shock treatment, insulin therapy, of morphine, synthetic sedation, tranquillizers, etc., into clinical usage, would cross-index the changes going on in the field of psychiatry. And the book can perhaps be very useful to those who are directly or indirectly involved in the administration of the mental hospital through the study of the life and work of one hospital in depth. To the last group of people, this reviewer hopes that the book could, in addition, inspire compassion and dedication which may sadly become qualities of the past, since in these years psychiatric hospitals, at least in the United States, are being established in the fashion of opening chain stores or motels.

PING-NIE PAO

Short Book Notices

Young Children in Hospital. Second edition. By JAMES ROBERTSON. London: Tavistock. 1970. Pp. xv + 155. 80p.

This is a second edition of Mr Robertson's well-known book, first published in 1958, and contains a postscript which outlines recent trends in Great Britain, with particular reference to the unique contribution of informed public opinion mobilized to hasten the implementation of the Platt Report. Further consideration is also given to the substantial obstacles that still stand in the way of achieving optimal care of the young child in hospital.

Readings in Extraversion-Introversion. 1. Theoretical and Methodological Issues. Edited by H. J. EYSENCK. London: Staples Press. 1970. Pp. 416. £4.00.

This is the first of three volumes containing papers on this area of personality study. The first volume includes a general introduction and covers theoretical and methodological issues in the study of Extraversion-Introversion. These issues centre on Extraversion-Introversion as a measurable dimension of personality and on its relationship with certain central nervous system variables. Several sections deal with issues of research methodology; the validity of the Extraversion-Introversion concept as assessed by personality questionnaires and behaviour ratings; the problem of 'response set' both as an intrinsic feature of extravert-introvert behaviour and as a general form of response bias to questionnaires measuring Extraversion-Introversion; the use of correlational statistics in studying the various behavioural correlates of Extraversion-Introversion; and, finally, the genetic basis of Extraversion-Introversion and its relation to children's personalities and behaviour.

Experience, Affect and Behavior. Edited by DAVID W. ROBINSON. Chicago: University of Chicago Press. 1969. Pp. xx + 511. £5.75.

This volume contains a selection of 28 papers written by Dr Adelaide Johnson, including her

well-known articles on parental sanctions in the development of conscience defects (superego lacunae) and school phobia. In these papers Dr Johnson covers a broad spectrum of psychopathology, from childhood disorders and the behaviour of delinquent adolescents, to psychosis and murder.

Man and His Culture: Psychoanalytic Anthropology after Totem and Taboo. Edited by WARNER MUENSTERBERGER. London: Rapp & Whiting. 1969. Pp. 397. £4.20.

The essays in this anthology represent theoretical and practical contributions to psychoanalytic anthropology. Since the original appearance of Freud's *Totem and Taboo* in 1913 psychoanalysis has advanced a long way, and this is evident in the writings on the impact of sociocultural and environmental factors on the development and character of the individual. Dr Muensterberger has written introductory notes to each contribution, and the volume is intended to show the advances to date in the application of Freudian psychoanalysis to the study of man and culture.

Diseases of the Nervous System. By SIR FRANCIS WALSHE. Edinburgh: Livingstone. 1970. Pp. xv + 381. £3.00.

The 11th edition of Walshe's textbook contains chapters on 'the relationship of the liver to metabolic disturbances of the central nervous system' and 'lead poisoning of the nervous system' by John Walshe, in addition to revisions of the chapters which appeared in earlier editions.

Brain and Early Behaviour. Edited by R. J. ROBINSON. London and New York: Academic Press. 1970. Pp. xvi + 374. £5.00 (\$15.00).

This volume represents an attempt to analyse early behaviour from the viewpoint of the underlying brain mechanisms. The 19 papers cover the earliest beginnings of movement and of electrical activity in the foetal brain, and the behaviour of the premature and full-term newborn infant.

Included are studies on normal and abnormal infants, related to the development of sleep, of visual perception, and of learning capacity. A further perspective is provided by the study of behaviour and early communication in squirrel monkeys.

Personality Structure and Measurement. By HANS J. EYSENCK AND SYBIL B. G. EYSENCK. London: Routledge and Kegan Paul. 1969. Pp. xiii + 365. £3.15.

This book begins with a statement of the principles of typological research in psychology. Results and generalizations from the Eysencks' previous work are discussed in some detail. Several studies using personality questionnaires prepared by the authors, as well as those of other workers, are included. Part of the book deals with personality studies in children, and includes a chapter on personality structure in subnormal subjects. Sex differences in personality structure are also discussed.

Growing to Maturity. By DOROTHY M. BERRIDGE. London: Burns & Oates. 1969. Pp. 172. £1.25.

Sister Dorothy Berridge has written this book with the aim of showing how a child's natural and progressive development, involving the gradual formation of a personal conscience, is a process that educators, particularly religious educators, have to be aware of if they are to understand their students. The extent to which the adult community can contribute to the religious formation of children of different ages is discussed.

Psychiatry in a Changing Society. Edited by S. H. FOULKES AND G. STEWART PRINCE. London: Tavistock. 1969. Pp. xviii + 211. £2.50.

The papers appearing in this volume were all presented to the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association in 1965. The editors believe that they raise issues of interest and importance which cannot be confined within the relatively narrow frontiers of a scientific psychiatric group. The papers included are grouped into four parts. The first deals with two opposed views of social psychiatry, the second with problems encountered

in communities and institutions, the third with theoretical approaches, and the fourth contains a general summary and conclusions.

Modern Trends in Psychological Medicine-2. Edited by JOHN HARDING PRICE. London: Butterworth. 1970. Pp. ix + 381. £5.50.

Over 20 years have passed since the appearance of the first book in this series, and the second volume is the response to the need for an authoritative collection of articles consolidating techniques presently being used by psychologists, psychiatrists, hospital staffs, clinicians and statisticians.

Episodic Behavioral Disorders. By RUSSELL R. MONROE. Harvard and London: Harvard University Press and Oxford University Press. 1970. Pp. xix + 517. \$11.00; £5.25.

Dr Monroe attempts a classification of the episodic behavioural disorders (atypical seizures, impulsivity, acting out, and other remitting disorders) that utilizes phenomenological, dynamic and aetiological considerations.

Congenital Mental Retardation. Edited by GORDON FARRELL. Austin and London: University of Texas Press. 1970. Pp. xii + 356. £4.75.

The 22 papers in this volume emphasize the new discoveries about congenital diseases that damage the central nervous system, and the contributors represent active workers in the field. The papers were presented at an international symposium in November 1967, and the participants included physicians, research scientists, lawyers, legislators, and concerned citizens.

Psychiatry and Its History. Edited by GEORGE MORA AND JEANNE L. BRAND. Springfield, Ill.: Thomas. 1970. Pp. xviii + 283. \$9.00.

This book brings together the collected views of a panel of psychiatrists and historians. It attempts to analyse some of the problems facing the specialist who seeks to explore historical landmarks in his field and to describe the essential tools which must be employed in the research and writing of sound medical history. The authors also

examine comparative interdisciplinary approaches to psychiatric history and the changing content of psychiatry in the 20th century.

The Wish to be Free. By FRED WEINSTEIN AND GERALD M. PLATT. Berkeley, Calif. and London: University of California Press. 1970. Pp. viii + 319. £4.05.

This book deals with the recurrent ideological and behavioural mandates that characterize the process of modernization. Going beyond the classical sociological critiques of this process, particularly of the demands made for rationality, self-discipline, and emotional constraint, the work attempts to demonstrate that the emotional consolations provided by traditional society and interrupted by modernization are inextricably linked to passive, dependent relationships to authority, and that some degree of personal autonomy and social inclusion is achieved and maintained only on the basis of rational control of affect.

Experimental Psychology: Its Scope and Method, vol. 4: *Learning and Memory*. Edited by PAUL FRAISSE AND JEAN PIAGET. London: Routledge & Kegan Paul. 1970. Pp. viii + 376. £4.00.

The first chapter of the book is concerned with conditioned reactions. Jean François le Ny discusses ways in which conditioned reactions are acquired and the laws governing their function.

The second contributor, Gérard de Montpellier, looks at different types of learning. The varying processes involved in both animal and human learning are considered, together with some general factors and mechanisms of learning. The third section of the book, by Geneviève Oléron, deals with the phenomenon of transfer. Among the topics included are the determination of transfer effects, transfer in perceptual-motor activities and explanations of transfer. In the final chapter, César Florès examines memory, forgetting and reminiscence. The discussion covers methodology, the influence of material, the role of practice, the part played by attitudes, motivation and emotive reactions in the memory process, as well as the importance of organization of memory tasks on the part of the subject.

Parenthood: Its Psychology and Psychopathology. Edited by E. JAMES ANTHONY AND THERESE BENEDEK. Boston, Mass.: Little, Brown. 1970. Pp. xxiv + 617. \$15.00.

The text of this book focuses on parenthood in the context of the biological and environmental evolution of human behaviour. The editors' intention is to present parenthood not as it relates to a fixed time and place but as a process in continual change. Material is presented from a range of interrelated fields, but a consistent psychobiologic approach is maintained. The extensive references may make this volume a source book in the area of family studies for both students and researchers.

The Basis of Motor Control. By RAGNAR GRANIT. London and New York: Academic Press. 1970. Pp. vii + 346. £5.00; \$14.50.

The last two decades have produced exciting developments in the field of motor activity. This study aims at a teleological understanding of the integrated functions and biological adaptations of motor activity. The book begins with a presentation of the pertinent physiological facts and goes on to discuss present knowledge at a more advanced level.

The Care and Training of the Mentally Subnormal. Fourth edition. By CHARLES H. HALLAS. Bristol: John Wright. 1970. Pp. 286. £2.60.

This book aims at being an up-to-date textbook for those undertaking examinations in the nursing of the mentally subnormal. Although written primarily for nurses, it will be helpful to medical students, social workers, health visitors, and to all those whose work brings them into contact with the mentally subnormal person or who may wish to care for their child in their own home.

Fitting the Task to the Man: an Ergonomic Approach. By E. GRANDJEAN. London: Taylor & Francis. 1969. Pp. 161. £4.50.

This is the English-language edition of *Physiologische Arbeitsgestaltung* originally published in 1963. Professor Grandjean's aim was to bring knowledge of physiology to those people who could make use of it. His work was reprinted in a second edition in 1967, and has been translated into

several foreign languages. The second edition has been fully re-edited and enlarged, and shows the influence of the fact that work physiology has become firmly established within the wider discipline of ergonomics. The knowledge gained from the application of work physiology is of interest to anyone who is involved in the organization of work, to the factory owner or manager, to the architect, to the designer of machines, to the management consultant, to the technical college teacher and to the factory doctor.

Fifty Years of the Tavistock Clinic. By H. V. DICKS. London: Routledge & Kegan Paul. 1970. Pp. xiv + 415. £4.20.

This book commemorates the men and ideas that started, inspired and established a pioneer institution in British psychiatry. Based on the impetus of Freudian and related innovations after the First World War, the Tavistock Clinic offers treatment, training and research facilities in the field of neurosis, child guidance and latterly group relations.

Dr Dicks, who has been associated for nearly 40 years with the work and personalities that helped to develop the Tavistock venture, describes the struggles and capacity for survival of the Clinic. He shows how, belonging neither to the older classical psychiatry nor to orthodox psychoanalysis, and suspect to both, the Clinic nevertheless became increasingly used by the rest of the profession as a psychotherapeutic resource. Dr Dicks describes the influence of the Tavistock on the medical, psychological and social work scene both before and after the Second World War, and assesses its achievements as a centre of psycho- and sociodynamic thinking.

The Tavistock is shown as a pioneer *sui generis*, launching psychosomatic research and initiating the exciting ventures in social psychiatry associated with the army in the Second World War. As the Tavistock was the outcome of work with shell-shock victims in the First World War, so its offspring, the Institute of Human Relations, was the natural continuation of the military effort in management, morale and group dynamic studies. The book includes an account of the interrelationship between the Clinic, now part of the National Health Service, and the Institute, a private corporation.

The Psychoanalytic Study of the Child. Volume XXIV. Edited by ANNA FREUD, R. S. EISSLER, HEINZ HARTMANN, MARIANNE KRIS AND OTHERS. London: Hogarth Press. 1970. Pp. 531. £5.00.

The present volume, number 24 in the well-known series, offers twenty contributions organized around four principal subjects: Contributions to Psychoanalytic Theory; Aspects of Normal and Pathological Development; Clinical Contributions, and Applications of Analysis.

Sociotherapy and Psychotherapy. By MARSHALL EDELSON. London and Chicago: University of Chicago Press. 1970. Pp. xviii + 266. £5.40.

In this book, the author seeks to provide sociotherapy with a theoretical foundation. A result of this endeavour is his definition of the 'therapeutic community', which is a theoretical one, rather than ideological or humanistic, and specific in its technical implications. The author begins by asking questions about the relation between psychotherapy and sociotherapy in the treatment of schizophrenia in psychiatric hospitals or residential treatment centres. To help answer such questions, he develops a comprehensive theory of groups. This theory illustrates the application of the general systems theory of Talcott Parsons. A way in which the personality theory of psychoanalysis and a theory of groups can be integrated is suggested.

Dr Edelson also formulates a systems theory of organization and, in particular, a theoretical model for the organization of the psychiatric hospital.

The Shape of Intelligence: the Evolution of the Human Brain. By H. CHANDLER ELLIOTT. Hemel Hempstead: Allen & Unwin. 1970. Pp. xiv + 303. £2.40.

In this study the author views the development of the human brain as the climax of a quest for intelligence, for power to achieve and to experience. He believes that this quest has been a steady and significant trend in evolution. The author contrasts human life with other forms of life, pointing out the similarities and differences, and attempts to trace the series of events that have led to the development of the human brain. In an

unusual appendix Dr Elliott presents an unconventional account of life without nervous systems – life in the vegetable kingdom. A comprehensive glossary and an index add to the usefulness of the work.

Schizophrenia: Research and Theory. By WILLIAM E. BROEN, JR. New York: Academic Press. 1968. Pp. x+240. \$11.00.

The marked increase in experimental studies of schizophrenia over the past two decades has led to a number of intriguing research questions. This work attempts a comprehensive review and an in-depth analysis aimed at facilitating understanding of the research and theory on this most common form of abnormal behaviour. The book's major focus is on the broad, interrelated areas of response interference, attention and cue utilization, and physiological arousal and inhibition.

A Gift of Life: Observations on Organ Transplantation. By ROY CALNE. New York: Basic Books. 1970. Pp. x+117. \$5.95.

The author, professor of surgery at Cambridge, discusses the many complex medical, legal and ethical questions raised by organ transplantation.

The Dream in Psychoanalysis. By LEON L. ALTMAN. New York: International Universities Press. 1969. Pp. viii+227. \$7.50.

In recent years, psychoanalysis has witnessed an upsurge of interest in ego psychology, while at the same time there has been a diminution of emphasis upon the dream. The author attempts to remedy the fact that many of those recently trained in psychoanalysis do not know what to do with the dream, by providing a volume on the technique of dealing with the dream in psychoanalysis.

Human Adaptation and Its Failures. By LESLIE PHILLIPS. New York: Academic Press. 1968. Pp. xiii+271. \$10.50.

This work attempts to provide a developmental model of human adaptation, encompassing psychiatric disorders, criminal behaviour, social malfunctioning, and psychosomatic disturbances. These conditions are viewed as responses to arrested or incomplete maturation and are seen as expressions of the individual's attempt to cope with problems behind the scope of his adaptive resources. The author focuses upon interpersonal behaviour, as opposed to intrapsychic dynamics, and presents a theoretical foundation for community and milieu orientated programmes of treatment.

Conduct and Conscience. By JUSTIN ARON-FREED. New York: Academic Press. 1968. Pp. viii+405. \$12.50.

This monograph analyses the origins of internalized control of behaviour within the broader framework of the socialization of the child. The phenomena of socialization are used to develop a general theoretical conception of the nature of children's learning in a social environment. The first two chapters outline the problems which are engaged by an account of the acquisition of conduct and conscience. The third chapter redefines these problems in terms of the concept of internalization. The fourth chapter, which is the theoretical core of the monograph, is an extensive analysis of the affective and cognitive mechanisms of learning which underlie socialization. The remaining eight chapters employ this analysis of mechanisms in a series of experimental demonstrations and descriptive analyses of the acquisition of specific internalized products of socialization. The treatment of socialization ranges from the findings of laboratory and field investigations of animal behaviour to the varieties of internalized control within and across the structure of societies. But the focus of the monograph is on an extensive body of experimental and naturalistic investigations of the behaviour of children.

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This is to announce a Weekend Conference to celebrate the first 20 years of the Hampstead Clinic.

This celebration will take the form of a Scientific Programme under the title: 'Developments in Child Psychoanalysis in the last Twenty Years: Pure and Applied'. The Conference will take place in London from Friday 21 July to Sunday 23 July 1972 inclusive.

The exact location and other details will be announced later.

Application forms can be obtained from Mrs C. S. Thurtle, Administrative Officer, Hampstead Child-Therapy Clinic, 21 Maresfield Gardens, London, N.W.3, England.

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